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LEGAL AND PRACTICAL PROBLEMS ARISING FROM SUBROGATION CLAUSES IN HEALTH AND ACCIDENT POLICIES

BY REX CAPWELL* AND THOMAS E. GREENWALD**

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I. INTRODUCTION

This article explores the legal and practical problems of recoupment under insurance policy subrogation clauses.

Black defines the term "subrogation" as:

A legal fiction through which a person who, not as a volunteer or in his own wrong, and in the absence of outstanding and superior equities, pays a debt of another, is substituted to all

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rights and remedies of the other, and the debt is treated in equity as still existing for his benefit, and the doctrine is broad enough to include every instance in which one party pays the debt for which another is primarily answerable¹

This article discusses the following questions:

1. Is a subrogation clause in an insurance policy or a medical expense plan valid?
2. Against whom can the insurer proceed to recover payments made to its insured?
 - a. The tortfeasor or the insured;
 - b. Other insurers;
 - (1) Liability carriers;
 - (2) Other carriers providing similar first party benefits, including Uninsured Motorist carriers.
3. How are proceeds divided between:
 - a. Subrogated party and claimant;
 - b. Multiple subrogated parties.
4. How are proceeds divided where:
 - a. comparative negligence has been adopted
 - b. contributory negligence bars recovery
 - c. available proceeds are inadequate.
5. What are the rights of an attorney to collect fees from a subrogated party where he obtains recovery for his injured client and the subrogated party?
6. What problems arise when court approval of the settlement is required?

Various types of insurance policies offer "first party" benefits with subrogation provisions. The benefits are offered in a Health and Accident policy and in prepaid medical plans such as "Blue Cross—Blue Shield." The benefits are also often found in liability package policies such as: Family Combination Automobile Insurance, Homeowner's Policy—Renter's Insurance, Comprehensive Personal Liability Insurance and certain Business Owner's policies.

In Health and Accident policies compensation to an injured insured is the essence of the contract. However, in automobile liability policies, fire insurance policies, and homeowner's insurance a medical expense provision is generally included as an incentive to purchase. These policies may or may not include a subrogation clause, but inclusion of subrogation clauses is on the increase. The desire to eliminate double recoveries is a natural response to the public's demand for lower costs and faster payouts. The automobile policy contains two basic agreements providing "Expenses for Medical Services" and are added to the com-

¹ BLACK'S LAW DICTIONARY (4th ed. 1957) at 1595.

mon fire and liability policies in order to attract policyholders or for more subtle ends.²

The provision providing for subrogation in the event of payment is not always found where the first party benefits are provided. Some of the prepaid plans do include subrogation provisions. However, it has been the exception rather than the rule.

Because "subrogation" has only recently gained in popularity, much of the law is unsettled. Only several of the problem areas mentioned above have been examined by enough jurisdictions to find a trend or a general rule. However, the courts are not distinguishing cases on the basis of the nature of the particular policy, that is, whether or not the policy or contract in issue is a health policy, a prepaid medical plan, or a family automobile liability policy. As a result, while many of the cases discussed in this article arose out of a Medical Payments provision in an automobile insurance policy, the rules would be the same for health and accident insurance or prepaid medical plans.

II. VALIDITY OF SUBROGATION PROVISIONS.

The right of subrogation generally can only be claimed where the policy specifically provides for such. However, in addition to the specific provision, payments will rarely be made to an insured under a medical payments endorsement until the insured acknowledges the right of the carrier to be subrogated to his interest.³ Such acknowledgement usually takes one of three forms: (1) subrogation agreement; (2) "trust" agreement; or (3) a "loan receipt" agreement. The first merely provides that the insured's rights against any third party, to the extent payment has been made, pass to the insurer. The "trust" agreement generally states that the insured shall retain as a trust for the benefit of the insurer an amount received by the insured from any party liable to him for his injuries to the extent of the medical payments made by the insurer.⁴ The "loan receipt" states that the sum which the insurer expends for the insured's medical expenses is considered to be a loan

² For instance, the "Medical Payments" and "Uninsured Motorist" protection plans included in the Standard Family Combination Automobile Policy are in part a response and alternative to the demands for "no fault" automobile insurance. See Pourous, Melendes, and Craig, 52 MARQ. L. REV. 445, 446-47 (1969) and 53 MARQ. L. REV. 320, 323-24 (1970).

³ *Smith v. Motor Club of America Ins. Co.*, 54 N.J. 37, 148 A.2d 37 (1959); *aff'd* 56 N.J. Super. 203, 152 A. 2d 369 (1959); *cert. denied*, 30 N.J. 563, 154 A.2d 451 (1959); *Davenport v. State Farm. Mut. Auto. Ins. Co.*, 81 Nev. 361, 404 P.2d 10 (1965); *Geertz v. State Farm Fire & Cas. Co.*, 451, P.2d 860 (Ore. 1969).

⁴ *Subrogation in Medical Service Plans and Medical Insurance Policies*, 12 PERSONAL INJURY COMMENTATOR 147, 150 (1969); *Miller v. Liberty Mutual Fire Ins. Co.*, 48 Misc.2d 102, 264 N.Y.S.2d 319 (1965) *aff'd* 289 N.Y.S.2d 276 (1968).

which is to be repaid only if the insured recovers from a party liable to him for his injuries.⁵

In essence, all three are merely another subrogation agreement, which cannot exist without the existence of the typical subrogation clause in the original contract, since no separate consideration is given in return for the agreement to subrogate. However, some courts do distinguish the cases on the basis of the subsequent agreement form.

The issue of the validity of a subrogation clause, like most legal issues, finds its way into the courts in a wide variety of factual settings. Some of the more common are:

1. An insurer, having paid its insured's medical expenses, may attempt to recover them directly from the tortfeasor or his insurer;⁶
2. An insurer, having paid its insured's medical expenses and having notified the tortfeasor's liability carrier of its subrogation claim, sues the liability carrier where it ignores the subrogation claim and makes a settlement with the injured insured which includes an amount for the medical expenses of the injured party;⁷
3. An insurer may sue its insured for sums expended when the insured, in violation of the subrogation agreement, settles with the tortfeasor or his liability carrier, thereby destroying the insurer's right of subrogation;⁸
4. An insured, having negotiated a settlement with or obtained a judgment against a tortfeasor, which included an amount for medical expenses, sues his insurer for the same expenses and seeks to have the subrogation provision declared void as against public policy;⁹
5. An insured may sue his insurer for medical expense payments when the carrier has refused to make such payments until the

⁵ For a discussion of loan receipts *see* 16 COUCE ON INSURANCE (2d) § 61:72-90 (1966); *See also* Courtney v. Birdsong, 437 S.W.2d 238 (Ark. 1968); Geertz v. State Farm Fire & Cas. Co., 451 P.2d 860 (Ore. 1969); National Union Fire Ins. Co. v. Grimes, 278 Minn. 45, 153 N.W.2d 152 (1967); Wilson v. Tennessee Farmers Mut. Ins. Co., 219 Tenn. 560, 411 S.W.2d 699 (1966).

⁶ Lowder v. Oklahoma Farm Bureau Mut. Ins. Co., 436 P.2d 654 (Okla. 1967); Travelers Ins. Co. v. Lutz, 3 Ohio Misc. 144, 32 Ohio Op. 2d 469, 210 N.E.2d 755 (1964).

⁷ State Farm Mut. Auto. Ins. Co. v. Farmer Ins. Exchange, 22 Utah 2d 183, 450 P.2d 458 (1969); Association Hosp. Service, Inc. v. Milwaukee Auto. Mut. Ins. Co., 33 Wis. 2d 170, 147 N.W.2d 225 (1967); Davenport v. State Farm Mut. Auto. Ins. Co., 81 Nev. 361, 404 P.2d 10 (1965).

⁸ National Union Fire Ins. Co. v. Grimes, 278 Minn. 45, 153 N.W.2d 152 (1967); Hospital Service Corp. of R.I. v. Pennsylvania Ins. Co., 227 A.2d 105 (R.I. 1967); Metropolitan Life Ins. Co. v. Ritz, 70 Wash. 2d 317, 422 P.2d 780 (1967); Harleysville Mut. Ins. Co. v. Lea, 2 Ariz. App. 538, 410 P.2d 495 (1966); Travelers Indemnity Co. v. Chumbley, 394 S.W.2d 418 (Mo. Ct. App. 1965); Michigan Medical Service v. Sharpe, 339 Mich. 574, 64 N.W.2d 713 (1954).

⁹ Wilson v. Tennessee Farmers Ins. Co., 219 Tenn. 560, 411 S.W. 2d 699 (1967); Miller v. Liberty Mutual Fire Ins. Co., 48 Misc.2d 102, 264 N.Y.S.2d 319 (1965).

insured executes an agreement subrogating the insurer to the proceeds of any recovery which the insured may obtain; and¹⁰

6. An insured may sue his insurer for medical payments when the carrier has refused to make such payment because the insured has settled with and released the tortfeasor, prejudicing the insurer's subrogations rights.¹¹

The issue of the validity of the subrogation provision has been decided, either directly or indirectly in 32 jurisdictions in the United States. Of the 32 jurisdictions, 26 have held that the provision is valid, while only six jurisdictions have held the provision invalid for one of several reasons.¹²

A. *Subrogation clause held invalid.*

Six states (Arizona, California, Georgia, Missouri, Oklahoma, and Virginia)¹³ hold that an insurer may not rely on its subrogation clause in any dispute concerning payments made to an insured or claimed to be owing an insured to compensate him for personal injury suffered as a result of the negligent acts of a third person. Of the six, two have restricted its use by statute, the other four jurisdictions have done so by common law.

Subrogation provisions have been invalidated on the theory that the common law prohibits the assignment of a cause of action for a personal injury claim, or the splitting of a cause of action for personal injuries.

These reasons have not been uniformly accepted, and have been discarded in favor of the development of compensation plans which more readily compensate the accident victim. However, the minority view has some points worth consideration by anyone interested in the reform of our present system of compensation.

*Travelers Indemnity Company v. Chumbley*¹⁴ is typical of the reasoning in the opinions which have held that the typical subrogation clause in a medical payments policy or contract for services is invalid because it is an assignment of a personal injury claim. In *Chumbley* the plaintiff-insurer had paid a portion of its insured's medical, surgical and hospital expenses under a medical payments endorsement contained in a family automobile insurance policy. The insured had sustained serious

¹⁰ *Demmery v. National Union Fire Ins. Co.*, 210 Pa. Super. 193, 232 A.2d 21 (1967); *Peller v. Liberty Mutual Fire Ins. Co.*, 220 Cal. App. 2d 610, 34 Cal. Rptr. 41 (1963).

¹¹ *Shipley v. Northwestern Mut. Ins. Co.*, 244 Ark. 1159, 428 S.W.2d 268 (1968); *Bush v. Home Ins. Co.*, 97 N.J. Super. 54, 234 A.2d 250 (1967); *De Cespedes v. Prudence Mut. Cas. Co.*, 193 So. 2d 224 (Fla. Ct. App. 1966); *Wrightsmen v. Hardware Dealers Mut. Fire Ins. Co.*, 113 Ga. App. 306, 147 S.E.2d 280 (1966); *Bernardini v. Home and Auto. Ins. Co.*, 64 Ill. App. 2d 465, 212 N.E.2d 499 (1966); *Anderson v. Allstate Ins. Co.*, 266 N.C. 309, 145 S.E.2d 845 (1966).

¹² See Appendix A.

¹³ *Id.*

¹⁴ 394 S.W.2d 418, 19 A.L.R.3d 1043 (Mo. App. 1965).

injuries, including the amputation of his right leg at the knee when he attempted to prevent an unoccupied vehicle from rolling down a hill in a heavily traveled thoroughfare. Chumbley, the injured party, subsequently brought suit against the owner of the runaway vehicle. The suit was dismissed with prejudice under stipulation, after Chumbley had settled out of court. Subsequent to making its payment, but prior to the dismissal of Chumbley's action, the carrier notified the owner of the runaway vehicle of its subrogation rights under its policy issued to Chumbley.

After the carrier discovered the settlement reached by Chumbley, he brought suit against Chumbley and against the owner. The actions were dismissed on the defendant's motions for summary judgment. On appeal, the trial court's ruling was affirmed. Justice Stone, in writing the opinion, stated that Missouri case law prohibited the assignment, in whole or in part, of a cause of action. He went on to state that medical expenses, as distinguished from property damage, is an integral part of an injured party's personal injury claim, and as such, not assignable. The opinion relied upon an older California case holding that an insurer's alleged right to be subrogated to medical payments coverage afforded by an automobile policy, constituted an assignment of a cause of action for personal injuries. However, the court felt duty bound to expand its reasons for invalidating the subrogation clause:

(I)nsuring against expenses payable under automobile "medical payments" coverage . . . has become so "useful and widespread" that many, if not most, of those who carry automobile medical payments coverage also have other coverage of some character (e.g., coverage under hospital and medical service plans such as Blue Cross and Blue Shield . . .) designed to pay . . . some or all of the expenses payable under automobile medical payments coverage.

If *some* automobile insurers making the subrogation "condition" in their policies applicable to medical payments coverage were to obtain judicial approval thereof, no doubt *all* such insurers would, in due course, similarly condition their policies. And, if *automobile insurers* were to insist upon subrogation as to medical payments coverage, *others* affording coverage against all or some of the same expenses logically would be justified in insisting upon subrogation . . . Thus the nurturing of subrogation as to medical payments would give substance to the unwelcome specter of multiple subrogation claims . . . (which) would lead to conflicts and disputes . . . would encourage and promote suits and interpleaders, all running counter to the policy of the law.¹⁵

¹⁵ *Id.* at 424. 19 A.L.R.3d at 1052-53. See also *Forsthove v. Hardware Dealers Mut. Fire Ins. Co.*, 416 S.W.2d 208 (Mo. App. 1967) where the court added that because the gist of damages in personal injury cases were for physical and mental pain, they should not be the subject of barter or trade—a matter of profit to the injured party's creditors.

(The following cases, in addition to *Chumbley* and *Forsthove*, have held that a subrogation clause in a contract providing medical expenses to its in-

The subrogation provision has also been invalidated on the ground that it violates the common law rule against the splitting of a cause of action. In *Lowder v. Oklahoma Farm Bureau Mutual Insurance Company*,¹⁶ an insurer, having paid the medical expenses of its insured after he was injured in an automobile accident, brought suit against the alleged third party tortfeasor. The insurer alleged that it had a right to reimbursement from the tortfeasor as a subrogated party, having obtained its subrogation rights under an express provision in the automobile policy it had issued to the injured party. The Oklahoma Supreme Court, in overruling a judgment for the insured, pointed out that a single tort to a single person only gave rise to one cause of action. Since the insured had not yet brought a claim against the tortfeasor for the recovery of personal injuries or property damage, permitting the insurer to bring a separate action to recover the medical expenses would violate the common law rule against the splitting of a single cause of action.¹⁷

Virginia,¹⁸ California¹⁹ and Georgia²⁰ have passed statutes restrict-

ured on no-fault basis is invalid as an attempted assignment of a cause of action for personal injuries: *Fifield Manor v. Finston*, 54 Cal. 2d 632, 7 Cal. Rptr. 337, 354 P.2d 1073 (1970); *Harleysville Mut. Ins. Co. v. Lea*, 2 Ariz. App. 538, 410 P.2d 495 (1966); *Wrightsmen v. Hardware Dealers Mut. Fire Ins. Co.*, 147 S.E.2d 860 (Ga. App. 1966); *Peller v. Liberty Mut. Fire Ins. Co.*, 34 Cal. Rptr. 41 (Ct. of App. 1963).

(See also, Annot., *Subrogation Rights of Insurer Under Medical Payments Provision of Automobile Insurance Policy*, 19 A.L.R.3d, 1054 (1968); *W. Rogers, Insurance Subrogation in Auto Medical Payments Coverage*, 19 CLEVELAND STATE L. REV. 393 (1970); *Fleming, The Collateral Source Rule and Loss Allocation in Tort Law*, 54 CALIF. L. REV. 1478, 1547 (1968) [supporting contentions similar to those voiced by Justice Stone in *Chumbley*].

¹⁶ 436 P.2d 654 (Okla. 1967). But see *Hospital Service Corp. of R.I. v. Pennsylvania Ins. Co.*, 227 A.2d 105 (R.I. 1967). In this case the injured party was paid by Hospital Service and then settled with the liability insurer of the tortfeasor. The settlement was entered into even though the liability carrier had notice of the subrogation claim of Hospital Service. The court, in a suit commenced by Hospital Service against its subscriber, the tortfeasor and the liability carrier, held that since the defendants participated in the settlement with full knowledge of the plaintiff's claim, they were held to have acquiesced in the splitting of the subscriber's original cause of action.

¹⁷ It should be noted that there was no evidence before the court establishing whether or not the insured did in fact still possess a good cause of action against the tortfeasor. Actually, the insured had previously settled all claims he had and executed a release which contained a specific reservation relative to the medical expenses incurred by the insured and paid by the insurer. *Risjord-Austin*, 5 Automobile Liability Insurance Cases 6045 (1969).

¹⁸ VA. CODE ANNOT. § 38.1-381.2 (1970). Automobile liability medical benefit insurer not to retain right of subrogation to recover from third party.—On and after January one, nineteen hundred sixty-five no policy or contract of bodily injury liability insurance, or of property damage liability insurance, which contains any representation by an insurance company that such company will pay all reasonable medical expense incurred for bodily injury caused by accident to the insured or any relative or other person coming within the provisions thereof, shall be issued or delivered by any insurer licensed in this State upon any motor vehicle then principally garaged or principally used in this State, if such insurer retains the right of subrogation to recover all amounts paid on behalf of an injured person under the provision of the policy from any third party. (1964, c. 612.)

¹⁹ ANNOT. CALIF. CODE, *Probate* § 573.

ing the use of subrogation by insurance carriers. Virginia had previously implied in *Moorman v. Nationwide Mutual Insurance Company*,²¹ that an insurer could be subrogated to the rights of its insured against a third party tortfeasor to recover for the medical expenses it had paid to its insured if such was provided for under the medical payments endorsement. In *Moorman*, the injured party had settled with the tortfeasor and his liability carrier, Nationwide, for his personal injuries and medical expenses. The injured party then brought a separate action against Nationwide under the same policy, contending that as a passenger of the tortfeasor's vehicle, he was entitled to benefits under the medical payments endorsement, which he alleged was separately contracted for by the tortfeasor and a separate premium was charged by Nationwide to the tortfeasor, and that the injured passenger was a third party beneficiary of such contract. There was no provision specifically permitting the insurer to set-off payments made under its liability endorsement from the amount due a passenger under the medical payments endorsement, or vice-versa.

The Virginia Supreme Court held that each endorsement was a separate contract for the benefit of third parties, and permitted the insured to recover in the second action, notwithstanding the prior settlement. The court went on to state the following, implying that set-offs and subrogation provisions would be valid and controlling if included in the contracts:

The insurance contract was prepared by Nationwide. Had it intended to limit or reduce the amount of its liability for medical payments under Coverage "G", if other medical payments were available to the injured person under any other coverage of its policy, or from another source, it could easily have so provided.²²

Any attempt to use this language to support the validity of a subrogation contract has been precluded by the Virginia legislature by the adoption of § 38.1-381.2 in 1968. That section expressly prohibits the incorporation of a subrogation provision in medical expense coverage.²³

California, whose statute theoretically invalidates subrogation provisions has followed a peculiar course in several decisions. In two cases,

²⁰ GA. CODE ANNOT., Title 85 § 1805 *What not assignable*. A right of action is assignable if it involves, directly or indirectly, a right of property; but a right of action for personal torts or for injuries arising from fraud to the assignor may not be assigned.

In *Wrightsmen v. Hardware Dealers Mut. Fire Ins. Co.*, 113 Ga. App. 306, 147 S.E.2d 860, 861 (1966), the Court held that the standard subrogation clause included in the Medical Expense endorsement of an automobile insurance policy "amounted to no more than an agreement to assign a personal injury claim in the event of payment under the terms of the medical payments coverage of the policy of insurance." As such, it was void because prohibited by statute.

²¹ 148 S.E.2d 874 (Va. 1966).

²² *Id.* at 876.

²³ See note 18 *supra*, for text of statute.

*Fifield Manor v. Finston*²⁴ and *Peller v. Liberty Mutual Fire Insurance Company*,²⁵ the courts struck down an "assignment of proceeds" and an "assignment of a right to recovery to the extent of payments made" on the basis that both were essentially subrogation provisions which were prohibited by statute. However, in cases where the insured could assure himself of a double recovery, the courts had a different view.

In *Doods v. Bucknum*,²⁶ the injured party, a passenger in the alleged tortfeasor's automobile, received payments under the driver's family combination automobile policy—medical payments endorsement, and then brought suit against the tortfeasor which included a claim for medical expenses. The Court of Appeals held that the plaintiff was not entitled to a double recovery since the collateral source rule was inapplicable where the collateral source was generated by the tortfeasor.

In a subsequent district court case, *Cannizzo v. Guarantee Insurance Company*,²⁷ it was held that double recovery by the injured party would be prohibited where the medical payments endorsement provided a set-off from any amounts the company would be liable for under the liability provisions of the same policy.

Another extension of the "double recovery" prohibition was achieved in a decision rendered by the Superior Court for Los Angeles County in *Syne Tryper v. Merit Plan Insurance Company*.²⁸ In that case the court upheld a "reimbursement plan" whereby an insurer agreed to advance medical payments, but its ultimate liability to pay the medical expenses became fixed only in the event that the injured insured would be unable to recover such expenditures from the third-party tortfeasor.

(P)ossibilities of double recovery posed by this case and those similar to it constitute inequities against good conscience to which the court should not shut its eyes . . . One ought to seek to be made whole, but not enriched through an automobile accident . . .²⁹

medical service contract issued by a nonprofit organization, which, under the Statutes of California, was declared not to be an insurance business.

The most interesting decision which apparently diminishes the effect of the California Statute is *Block v. California Physicians' Service, Inc.*³⁰ This case involved a "reimbursement" provision in a prepaid

²⁴ 54 Cal. 2d 632, 7 Cal. Rptr. 337, 354 P.2d 1073 (1960).

²⁵ 34 Cal. Rptr. 41 (Ct. App. 1963).

²⁶ 214 Cal. App. 2d 206, 29 Cal. Rptr. 393 (Ct. App. 1965).

²⁷ 53 Cal. Rptr. 657 (1966).

²⁸ *Tryper v. Merit Plan Ins. Co.*, L.A. County Super. Ct., App. Dept. [Civ. No. 11085] (1965) [P., F. & M. Analysis Service, Current Court Decisions (Feb. 1966)].

²⁹ *Id.*

³⁰ 53 Cal. Rptr. 51 (Ct. App. 1966).

medical service contract issued by a nonprofit organization, which under the Statutes of California, was declared not to be an insurance business.

The contract provided that if the member was injured by a third-party tortfeasor, then the service pays medical benefits on the condition that the member agrees in writing:

- (1) to reimburse CPS to the extent of benefits provided, immediately upon collection of damages by him, whether by action at law, settlement or otherwise, and
- (2) to provide CPS with a lien, to the extent of benefits provided by CPS. The lien may be filed with the person whose act caused the injuries, his agent, or the court.³¹

The member said that such provisions were void under §956 of the Civil Code (§573 of the Probate Code) as a transfer of a cause of action. He contended that these provisions had been held invalid in the *Peller*³² decision. However, the court distinguished this case from *Peller* in two respects. In *Peller* these provisions appeared under the heading "Subrogation", while the CPS did not mention that term. The court also stated that the CPS provisions did not constitute a subrogation clause because the Service could not force the member to take any action against the tortfeasor—those rights generally being provided for in the standard subrogation provision in a medical payments endorsement of an insurance policy.³³

B. *Subrogation clause held valid.*

Without question the majority of the jurisdictions which have either directly or indirectly considered the validity of a clause which would permit an insurer to have a right to recoup its payments where the injuries suffered by an insured were caused by negligent acts of a third party, have held that such a clause is valid.³⁴ The courts have given various reasons for upholding the validity of the clauses, the most significant of which are as follows:

1. Subrogation provisions merely constitute conventional subrogation which does not constitute an assignment of a cause of action;
2. Present conditions in society command that the old common law rule prohibiting the assignment of a cause of action for personal injuries be repealed in favor of permitting such an assignment;
3. Subrogation provisions do not constitute an assignment of a cause of action, but rather impress a lien in favor of the party providing the benefits, to the extent that that party has made

³¹ *Id.* at 52.

³² *Peller v. Liberty Mut. Fire Ins. Co.*, 34 Cal. Rptr. 41.

³³ This may be the one case found where the type of contract changes the rule in regard to the validity of subrogation of an essential subrogation provision permitting the party providing the benefits some type of reimbursement from the tortfeasor. The court did stress the point that the contract in this case was for *services*, not *indemnity*.

³⁴ For a list of jurisdictions which have considered this issue, and for the results therein, see Appendix A.

payment, on the proceeds of any recovery obtained by the insured from the tortfeasor;

4. The right of subrogation, where provided for in a contract, is neither unfair nor over-reaching, and therefore should be given effect (some decisions highlight the fact that there is in fact an accompanying reduced premium);
5. The right of subrogation, where provided for in a contract cannot be considered contrary to public policy in the absence of action by the insurance department, which is vested, by the legislature, with duties concerning the approval of insurance policies.

Apparently one of the most popular reasons given for upholding a subrogation provision permitting the insurer or medical service plan to recoup, directly or indirectly, its payments is that such a subrogation clause constitutes pure and simple subrogation which can be and is distinguished from an assignment of a cause of action. *De Cespedes v. Prudence Mutual Casualty Company*,³⁵ perhaps explains the reasoning of the courts in the clearest manner. In *De Cespedes* an insured under an automobile policy which contained a medical payment provision brought an action against the insurer to recover for his medical expenses. Prior to bringing the suit the insured had settled with the third party tortfeasor and had executed a full release. The medical payments provision of the insured's automobile policy contained the standard subrogation clause, which included a provision that the insured "shall do nothing after loss to prejudice (the insurer's subrogation) rights." On the basis of that provision, the trial court granted the defendant insurer's motion for summary judgment.

On appeal the insured attacked the validity of the subrogation provisions arguing that the subrogation clause in fact constituted an attempt to assign a claim for personal injuries which was invalid under the common law and had not been altered by any statute. The court of appeals rejected such argument holding that the concept of subrogation was distinct from an assignment of a cause of action. Subrogation, explained the court, is a concept in equity adopted for the purpose of obtaining an equitable adjustment between the parties by securing the ultimate discharge of a debt by the person who in equity and good conscience is responsible to pay it.

Under the doctrine of subrogation the insurer is substituted, by operation of law, to the rights of the insured . . . It is not available to a volunteer, only to one under a duty to pay . . . By contract, an assignment generally refers to or connotes a voluntary act of transferring an interest . . .

. . . .

³⁵ 193 So. 2d 224 (Fla. App. 1967); *aff'd* 202 So. 2d 561 (1967).

(S)o long as subrogation as applied to this medical provision serves to bar double recovery, it should be upheld.³⁶

Rather than distinguish subrogation from assignment, several courts have merely abrogated the old common law rule prohibiting the assignment of a cause of action for personal injuries.³⁷ In *Davenport v. State Farm Mutual Automobile Insurance Company*,³⁸ the medical payments carrier prevailed in a suit against the tortfeasor and his insurer who had settled with the injured party who had previously been reimbursed for his medical expenses by the plaintiff. The tortfeasor and his insurer settled all claims with the injured party, notwithstanding the outstanding claim for medical payments made by the carrier against the defendants. The case was submitted on stipulated facts and was designed to test the validity of the subrogation provisions of the plaintiff's policy. The Nevada Supreme Court held that the modern rule in regard to assignment of a cause of action is that if the cause of action would survive the death of the person injured, as a cause of action for personal injury does, then that right is assignable. Therefore, a provision in a contract for medical payments which subrogates the company, to the extent of the medical payments made by it to the insured, to the rights of the injured party against the tortfeasor or those responsible for his negligent acts is valid.

Another method used by the courts to circumvent the common law rule prohibiting the assignment of interests has been to declare that the subrogation clause cannot operate to transfer the cause of action; however, it can operate to impress a lien in favor of the insurer or organization providing the benefits upon any recovery by the insured from the tortfeasor.

Illinois has followed this reasoning in two cases, *Damhesel v. Hardware Dealers Mutual Fire Insurance Company*,³⁹ and *Bernardini v. Home and Automobile Insurance Company*.⁴⁰ Both cases involved

³⁶ *Id.*, at 227; See also *State Farm Mut. Ins. Co. v. Farmers' Ins. Exchange*, 22 Utah 2d 183, 450 P.2d 458 (1969); *Travelers Indemnity Co. v. Rader*, 166 S.E.2d 157 (W. Va. 1969); *Shipley v. Northwestern Mut. Ins. Co.*, 244 Ark. 1159, 428 S.W.2d 268 (1968); *Miller v. Liberty Mut. Fire Ins. Co.*, 48 Misc. 2d 1021, 264 N.Y.S.2d 319, *aff'd* 289 N.Y.S. (1968); *Bradford v. American Mut. Liab. Ins. Co.*, 25 Pa. Super. 8, 245 A.2d 478 (1968) following *Demmery v. National Fire Ins. Co.*, 210 Pa. Super. 193, 232 A.2d 21 (1967); *Busch v. Home Ins. Co.*, 97 N.J. Super. 54, 234 A.2d 250 (1967); *Wilson v. Tennessee Farmers Mut. Ins. Co.*, 219 Tenn. 560, 411 S.W.2d 699 (1967); *Anderson v. Allstate Ins. Co.*, 266 N.C. 309, 145 S.E.2d 845 (1966); *Damhesel v. Hardware Dealers Mut. Fire Ins. Co.*, 60 Ill. App. 2d 279, 209 N.E.2d 877 (1965).

³⁷ *Davenport v. State Farm Mut. Auto. Ins. Co.*, 81 Nev. 361, 404 P.2d 10 (1965); *Travelers Ins. Co. v. Lutz*, 3 Ohio Misc. 144, 32 Ohio Op. 2d 469, 210 N.E.2d 755 (Mun. Ct. 1964).

³⁸ 81 Nev. 361, 404 P.2d 10 (1965).

³⁹ 60 Ill. App. 2d 279, 209 N.E.2d 877 (1965).

⁴⁰ 64 Ill. App. 2d 465, 212 N.E.2d 499 (1965); See also *Miller v. Liberty Mut. Fire Ins. Co.*, 48 Misc. 2d 102, 264 N.Y.S. 2d 319 (Spec. T. 1965), *aff'd* 289 N.Y.S.2d 276 (1968).

suits by the insured under the medical payments provision of his automobile insurance policy to recover for medical expenses where he had already settled with the tortfeasor and had executed a full release.

Notwithstanding the existence of the old common law rule against assignments, several decisions have held that the right of the insurer to be reimbursed to the extent of payments made or to be subrogated to the rights of its insured is based on a contractual right and that such contractual provisions are not unfair nor over-reaching, and often times are accompanied by an appropriately reduced premium.

In *National Union Fire Insurance Company v. Grimes*⁴¹ the insurer brought suit against its insured for medical payments reimbursement from proceeds of settlement made by the insured with the tortfeasor and his liability carrier. The policy issued to the defendant insured did not contain the so-called "reimbursement" clause nor had the insured executed any "reimbursement agreement" or "trust agreement" when accepting the payments from the plaintiff. However, the policy did contain the following subrogation provision:

In the event of any payment under the medical expense coverage of this policy, the company shall be subrogated to all the rights of recovery therefore which the injured person or anyone receiving such payment may have against any person or organization and such person shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. Such person shall do nothing after loss to prejudice such rights.⁴²

The Minnesota Supreme Court, in reversing the judgment for the insured entered in the trial court, stated:

Here the insurer is making a claim for reimbursement as against the insured . . . upon the ground that the contract obligates the defendant to repay the insurer if and when he recovers from the person who caused the damage . . . It is clear that the intentment of the contract is to that effect. We do not see any consideration of public policy which precludes the making of such an agreement.

The . . . defendant wished to obtain a policy of automobile liability insurance with medical payment coverage at a premium lower than that generally available. It seems reasonable to assume that the subrogation provision contained in this policy could result in the reduced premium. We think that unless there is a clear public policy to the contrary, a prospective insured should be free to secure insurance at the lowest possible premium available for the kind of coverage that satisfies him.⁴³

The same philosophy was used by the Michigan Supreme Court in *Michigan Medical Service v. Sharpe*,⁴⁴ a case which involved a prepaid medical service contract:

⁴¹ 278 Minn. 45, 153 N.W.2d 152 (1967).

⁴² *Id.*, 153 N.W.2d at 153.

⁴³ *Id.*, 153 N.W.2d at 155.

⁴⁴ 339 Mich. 574, 64 N.W.2d 713 (1954); *See Annot.*, 43 A.L.R.2d 1177 (1955).

The contentions of the defendant Sharpe are that to allow recovery by the plaintiff . . . "would mean permitting it to receive premiums without any obligations . . ." Enrichment of plaintiff is not unjust if pursuant to the express agreement of the parties, fairly and honestly arrived at . . . To agree with the defendant that the subrogation clause gave the plaintiff no rights whatsoever is to read it out of the agreement by rendering it meaningless. This a court may not do.⁴⁵

Other jurisdictions have also ignored the common law rule prohibiting assignments and have given effect to the contractual agreement based on the fact that the state insurance commission had approved the form of the policy in issue. For example, in *Smith v. Motor Club of America Insurance Company*,⁴⁶ an insured, having settled with the tortfeasor for an amount including medical expenses, brought suit against his insurer seeking to have the policy reformed by having the subrogation clause deleted, and then recovering his medical expenses under the medical payments provision. The insured alleged that the subrogation provision was illegal, void and against public policy. However, the court, in granting summary judgment for the insurer, held that the provision was presumed neither unfair, inequitable nor against public policy since the Commissioner of Banking and Insurance, who was vested with legislative authority to strike from any policy any clauses he deemed to be unfair or inequitable, took no action with respect to subrogation provisions applying to a medical payment endorsement in automobile insurance policies.

In at least two decisions the court examined all the reasons adopted by other courts in upholding the subrogation agreements, and without specifically adopting any one reason declared that the insurer may validly contract to pay medical expenses to an insured and then be subrogated to the insured's rights against a third party tortfeasor, to the extent of the payments made.⁴⁷

⁴⁵ *Michigan Medical Service v. Sharpe*, 64 N.W.2d at 714. See also *Sentry Ins. Co. v. Stuart*, 439 S.W.2d 797 (Ark. 1969). While Arkansas has continued to uphold the rights of subrogation by a company under a Medical Expense endorsement, it has continued to hold that a personal injury claim is not assignable. *Southern Farm Bureau Cas. Ins. Co. v. Wright Oil Co.*, 454 S.W.2d 69 (Ark. 1970); *Motto v. State Farm Mut. Auto Ins. Co.*, 462 P.2d 620 (N.M. 1969) [Because workmen's compensation cases permitted assignment of a cause of action, the court could not see any valid reason for holding subrogation provisions against public policy]; *Silinsky v. State-Wide Ins. Co.*, 289 N.Y.S.2d 541 (App. Div. 1968); *Hospital Ser. Corp. of R.I. v. Pennsylvania Ins. Co.*, 227 A.2d 105 (R.I. 1967); *Associated Hospital Service, Inc. v. Milwaukee Auto. Mut. Ins. Co.*, 33 Wis. 2d 170, 147 N.W.2d 225 (1967).

⁴⁶ 54 N.J. Super. 37, 148 A.2d 37 (1959); *aff'd* 56 N.J. Super. 203, 152 A.2d 369 (1959); *certification denied*, 30 N.J. 563, 154 A.2d 451 (1959). For a criticism of this case see *Travelers Indem. Co. v. Chumbley*, 394 S.W.2d 418 (Mo. App. 1965). See also *Busch v. Home Ins. Co.*, 97 N.J. Super. 54, 234 A.2d 250 (1967); *Bernardini v. Home and Auto. Ins. Co.*, 64 Ill. App. 2d 465, 212 N.E.2d 499 (1966); *Travelers Ins. Co. v. Lutz*, 3 Ohio Misc. 144, 32 Ohio Op. 2d 469, 210 N.E.2d 755 (1964).

⁴⁷ *Geertz v. Satte Farm Fire & Cas. Co.*, 451 P.2d 860 (Ore. 1969); *Higgins v. Allied American Mutual Fire Ins. Co.*, 237 A.2d 471 (D.C. 1968).

While subrogation is an equitable right, subrogation must be provided for in the contract or policy. This rule is emphatically brought out in two companion cases brought before the Michigan Supreme Court—*Michigan Hospital Service v. Sharpe*,⁴⁸ and another case by the same name.⁴⁹ In both suits the hospital service brought suit against the subscriber to recover payments made to the subscriber who, subsequent to receiving the services, settled with the tortfeasor and executed a full release of all claims against the tortfeasor.

In the first suit the contract in issue did not contain any subrogation or similar provisions, while in the second suit the contract did contain an express subrogation clause. The majority opinion in the first case held that the service was primarily liable for the medical expenses incurred by the subscriber and therefore was not entitled to recover on the basis of common law or equitable principles of subrogation, from the subscriber, who had obtained a settlement from the third party tortfeasor which included an amount for medical expenses.

Justice Dethmers, who dissented to the ruling in the first case, was the author of the opinion in the companion case. In the opinion Justice Dethmers stated that the earlier decision stressed, as a reason for the result, the absence of a subrogation clause in the contract or "certificate." The court found the provisions to be valid and not against public policy.⁵⁰ In concluding the opinion Justice Dethmers states:

In view of the holding in the companion case, liability, if any, to plaintiff here, can be predicated only upon the subrogation clause in the agreement.⁵¹

The leading case establishing the Wisconsin position is *Associated Hospital Service v. Milwaukee Automobile Insurance Company*.⁵² In that case, Associated Hospital Service (AHS), a Blue Cross service plan organization, had paid the hospital and medical care expenses of its subscriber, Josephine Opine. Miss Opine had been injured in an automobile accident caused by the negligence of Arthur Sievers, who was insured by the Milwaukee Automobile Insurance Company (Milwaukee). AHS, after paying the medical expenses of Miss Opine, notified Milwaukee that, pursuant to its contract with Mrs. Opine, it had acquired a subrogation right against Milwaukee and its insured to the extent of the medical payments made. Milwaukee settled with Mrs. Opine for her damages, which included a sum for her medical expenses, however, no payment was made to AHS. AHS then brought suit against

⁴⁸ 339 Mich. 357, 63 N.W.2d 638 (1954).

⁴⁹ Michigan Med. Ser. v. Sharpe, 339 Mich. 574, 64 N.W.2d 713 (1954); See Annot., 43 A.L.R.2d 1177 (1955).

⁵⁰ *Supra*, footnote 45.

⁵¹ Michigan Med. Service v. Sharpe, 64 N.W.2d at 714.

⁵² 33 Wis. 2d 170, 147 N.W.2d 225 (1967).

the liability carrier in an attempt to recover for the hospitalization and medical payments it had made to Mrs. Opine.

The case was one of first impression in Wisconsin. The court, in a well written opinion, noted that the leading decision in Wisconsin on subrogation under accident insurance policies, *Gatzweiler v. Milwaukee Electric Railway and Light Co.*,⁵³ denied that a contract of casualty insurance was one of indemnity where there was no expressed stipulation to the contrary, but did say that "the parties might give it that character by a stipulation to that effect."⁵⁴

The court was impressed by the fact that the subrogation provision in the AHS contract was aimed at avoiding duplication of coverage, was accompanied by an appropriately reduced premium, and was reviewable by the state Insurance Commissioner. It therefore decided to follow the majority of jurisdictions in upholding and enforcing an express agreement for subrogation.

C. Medical Payments Set Off from Liability.

When a liability carrier reimburses the insured for his medical expenses the company may then attempt to deduct that amount from the liability award. The typical set-off provision has been upheld as being valid notwithstanding the argument that the medical payments provision and the liability provision of the policy are separate provisions with separate premiums. This is an argument which is sometimes made in relation to the validity of the subrogation agreement and the treatment by the courts relating to the set-off provision may shed some light on how those jurisdictions would react if the validity of the subrogation provision of the medical payments clause was challenged.

In *Yarrington v. Thornburg*⁵⁵ the defendant driver sought allowance of credit after judgment for the payments previously made to his injured passenger under the medical expense provision of his liability insurance policy. The court, in an effort to avoid permitting double recovery by the injured passenger, permitted the credit to be made. The decision was based upon the court's conclusion that the collateral source rule, as applicable in Delaware, is not applicable where the collateral source is generated by the tortfeasor.

⁵³ 136 Wis. 34, 116 N.W. 633 (1908).

⁵⁴ *Id.* at 38, 116 N.W. at 634.

⁵⁵ A typical provision is as follows: "The Company may pay the insured person or any person or organization rendering the services and such payments shall reduce the amount payable hereunder for such injury." See *Gunte v. Ford*, 242 La. 943, 140 So. 2d 11 (1962).

⁵⁶ 198 A.2d 181 (Del. Super. Ct. 1964); *aff'd*, 205 A.2d 1 (1964). For a more detailed discussion of *Yarrington*, see: Burt, *A Recent Trend In Application of the Collateral Source Doctrine: Elimination of Plaintiff Passenger's Double Recovery for Medical Expenses*, 16 FED. INS. COUNSEL QUAR. 78 (1965).

The same result was reached in *Ekblade v. Anderson*,⁵⁷ where the court stated: "The ordinary purpose of automobile liability coverage is for the carrier to make good or pay, but once, in behalf of the insured, a claimant's damages as determined to be the proximate result of the negligence of the insured. No needed fair end or good is to be served by making payment twice for any part of medical expenses."⁵⁸

The Supreme Court of North Carolina reached the same result without relying upon an exception to the collateral source rule or to any particular provision in the insurance policy, but rather centered its attack entirely upon the abhorrence of a double recovery on the part of a passenger. The court stated:

In our opinion it was not within the contemplation of the contracting parties that there should be a double recovery of medical expenses. . . . It is manifestly inequitable for plaintiff to recover twice against the same defendant, even though payment was in part voluntary.⁵⁹

The Court went further and presented a hypothetical which brought the point home very strongly.

Consider the hypothetical, but quite probable, case where recovery is in excess of insurance limits, or a case where medical payments are provided by insurance and financial responsibility provided from defendant's personal assets; a court in such instances could not in good conscience sustain a double recovery for medical expenses.⁶⁰

While the above cases reject the argument that two types of insurance were purchased for the benefit of a third party and therefore benefits should be paid under both sections, a lower court in New York decided otherwise. In *Moore v. Leggette*,⁶¹ the injured guest, after being reimbursed for his medical expenses under the medical provisions of the host's liability policy, sued the host for an amount including his medical expenses. The host contended that the medical payments should be considered in mitigation of damages. The court disagreed saying:

Two distinct forms of protection have been supplied for two fees, and yet one payment here will relieve both obligations. This possibility of double charge—single payment insurance is even more unwarranted than this plaintiff might receive as a possible no-charge double recovery bonanza.⁶²

However, this decision did not stand upon appeal to the appellate division. The New York Court of Appeals affirmed the appellate divi-

⁵⁷ 28 Conn. Supp. 117, 255 A.2d 865 (1969).

⁵⁸ *Id.*, 255 A.2d at 866. See also language to same effect in earlier Connecticut cases: *Bruno v. Pinto*, 2 Conn. 431, 434; *L'Manian v. American Motorists Ins. Co.*, 4 Conn. Cir. 524, 236 A.2d 349 (1967).

⁵⁹ *Tart v. Register*, 257 N.C. 161, 125 S.E.2d 754, 764 (1962).

⁶⁰ *Id.*, 125 S.E.2d at 764.

⁶¹ 45 Misc.2d 603, 257 N.Y.S.2d 433 (1965).

⁶² 257 N.Y.S.2d at 466.

sion's reversal in a subsequent appeal thus preventing the plaintiff from obtaining a double recovery.⁶³

One of the more unusual decisions in the area of medical payments insurance, first party insurance and set-offs is the case of *Sims v. National Casualty Company*.⁶⁴ The Florida Court of Appeals held that while the medical expenses of the injured passenger were included in the arbitrated amount the insured was to receive under the uninsured motorist endorsement, the insured could also recover the same expenses under the medical payments provision. The court held that the two charges were separate and independent notwithstanding the finding that the carrier had a valid right of subrogation against the uninsured tortfeasor. The distinguishing element of the *Sims* case is that the injured insured was claiming under the uninsured motorist protection and the medical payments protection. The court stated that since the premiums for both coverages were paid by the insured, this situation should be distinguishable from suits for double recovery against the tortfeasor's insurer.

III. AGAINST WHOM CAN THE INSURER RECOVER PAYMENTS MADE TO ITS INSURED.

A. *The tortfeasor or the insured.*

The subrogation provision in an endorsement or contract providing medical expense benefits generally provides that the insurer obtains the rights of the insured against *any* party who might be liable to the insured in a civil action. Therefore, wherever the subrogation provision can be enforced, the insurer should be able to recover its payments from anyone liable to the insured. However, its rights may be limited.

Most jurisdictions have statutes providing that all necessary parties must be joined in an action; failure to comply with such a requirement would be grounds for the dismissal of the action.⁶⁵ As a result, an insurer may join its insured or the insurer may assign its rights to the insured for purposes of suit or vice-versa, rather than having several plaintiffs. Another alternative is to let the insured bring an action against those liable to him and the insurer merely gives notice to the defendants of its subrogation claim.

The most common procedure practiced today by insurers and hospitalization-medical plans is to let the insured or subscriber bring an action. The defendants are informed of the insurer's subrogation rights either prior or subsequent to suit. As a practical matter stipulations with

⁶³ *Reversed*, 24 App. Div. 2d 891, 264 N.Y.S.2d 765 (1965); *Reversal aff'd*, 18 N.Y. 2d 864, 22 N.E.2d 737 (1966).

⁶⁴ 171 So. 2d 399 (Fla. App. 1965).

⁶⁵ E.g. WIS. STAT. § 260.13 (1969).

respect to amount (but not liability) are often reached between the subrogated insurer and allegedly responsible third party. Unlike a subrogation claim for property damage, where the insured will not bring suit against the tortfeasor or other responsible party because his interest is limited to a deductible, the injured party who has substantial medical expenses will usually have a substantial enough personal injury claim to bring suit against all possible defendants.

The insurer's problems arise where the insured, after receiving payments from the insurer, settles with the tortfeasor or his liability carrier. If the insurer has given notice to all interested parties, he may have a cause of action against any one or all of the parties to the original settlement.

The standard subrogation clause contains the provision that the insured, after receiving payment from the company, shall not take any action to prejudice the rights of the company. In the event that the insured settles with the tortfeasor or any party liable for the acts of the tortfeasor for an amount which includes the medical expenses incurred by the insured and paid by the company, the company should have the right to sue its insured for breach of the policy. In several cases, this procedure has been affirmed by the courts.

In *Metropolitan Life Ins. Co. v. Ritz*⁶⁶ the defendant was injured as a result of the negligence of a third party. The plaintiff had paid the defendant \$1,865.39 for medical expenses pursuant to a policy containing a typical subrogation clause. In addition to this clause the policy contained a provision providing that in the event the insured had already been reimbursed for his medical expenses by the tortfeasor or one liable for the acts of the tortfeasor, then benefits under the medical payments provision were excluded.

After the defendant-insured received the payment from the plaintiff he arranged a settlement with the tortfeasor and the tortfeasor's liability carrier, and executed a release of *all* claims arising out of the accident caused by the negligence of the third party. The settlement was concluded notwithstanding the outstanding claim of the plaintiff, who had given notice to the tortfeasor and his insurer, and had obtained a reimbursement agreement from the defendant when it paid the defendant for his medical expenses.

The plaintiff brought suit against its insured and moved for summary judgment, alleging that the defendant had interfered with the rights of the plaintiff under the policy and had breached the "reimbursement" agreement. Plaintiff's motion was granted by the trial court on the basis that the subrogation rights of the plaintiff under the policy

⁶⁶ 70 Wash. 2d 317, 422 P.2d 780 (1967).

were violated because the release executed by the defendant for the benefit of the tortfeasor released all claims.⁶⁷

On appeal, the supreme court agreed with the plaintiff and the trial court, notwithstanding the admitted fact that the insurer had refrained from taking any action against the tortfeasor or his insurer because it had procured the "reimbursement agreement". The defendant, on appeal, had argued that since the plaintiff had not taken any steps against the tortfeasor he could not complain that those rights were prejudiced because of the defendant's settlement. As a result of the insurer's failure to take affirmative action the court held that it was only equitable that the insurer contribute a pro-rata share of the defendant's expenses incurred in arriving at the settlement with the tortfeasor.

The insurer, then, may proceed against the insured where the insured has prejudiced the subrogation rights of the insurer by settling his claims against the tortfeasor and executing a release for all claims. The basis of such a suit is breach of the contract.⁶⁸ But what is the basis for suit by the insurer against the tortfeasor or the liability carrier who, with notice of the subrogation rights, nevertheless proceeds to settle with the injured party and obtains a release of all claims which have or will accrue to the injured party as a result of the acts of the tortfeasor? This issue has been the subject of several cases,⁶⁹ some of which will be examined below.

In *Davenport v. State Farm Mutual Automobile Ins. Co.*,⁷⁰ the tortfeasor and his liability carrier ignored the plaintiff's subrogation rights for the medical expenses incurred by the injured party. The insurer then brought suit against the tortfeasor and his carrier to recover the amount of its subrogation interest. The Nevada Supreme Court, in upholding the right of the subrogee to maintain his action against these defendants, notwithstanding the complete release executed by the injured party, stated:

⁶⁷ The trial court did not base its motion on the "reimbursement" agreement because such was only a reaffirmation of the policy provisions and obligations.

⁶⁸ There is one case which has permitted the insurer to recover against the insured where there was a settlement but no reimbursement to the insurer, notwithstanding the possibility that subrogation for medical payments may have been barred because of the common law rule prohibiting an assignment of a cause of action for personal injuries. See *National Union Fire Ins. Co. v. Grimes*, 278 Minn. 45, 153 N.W.2d 152 (1967).

⁶⁹ *Hospital Service Corp. of R.I. v. Pennsylvania Ins. Co.*, 227 A.2d 105 (R.I. 1967); *Associated Hosp. Service, Inc. v. Milwaukee Mut. Ins. Co.*, 33 Wis. 2d 170, 147 N.W.2d 225 (1967); *Davenport v. State Farm Mut. Auto. Ins. Co.*, 404 P.2d 10 (Nev. 1965). See *State Farm Mut. Auto. Ins. Co. v. Mid-Century Ins. Co.*, 259 N.E.2d 424 (Ind App. 1970) where the issue was presented on appeal. However, the court refused to consider it because there was no evidence in the record as to whether the liability carrier settled with the injured subrogor after having received notice of the subrogation claim from the plaintiff.

⁷⁰ 81 Nev. 361, 404 P.2d 10 (1965).

We hold that, where the [medical payments] clause of an automobile liability insurance policy subrogates the company to the extent of the medical payments made by it to the assured "to the proceeds of any settlement that may result from the exercise of any rights of recovery which the injured person receiving such payments may have against any person," the tortfeasor (or his insurer) may not disregard that known subrogation (or lien) right in settling his liability.⁷¹

The opinion was not without dissent. Judge Collins argued that the plaintiff's cause of action was against its own insured who breached the policy provisions. The decision rendered in this case would penalize a party who was not a party to the contract which was breached, and the party who was guilty of the breach was rewarded in the form of a double recovery for the injuries he sustained.

The same result reached in *Davenport* was reached in *Hospital Service Corp. of Rhode Island v. Pennsylvania Ins. Co.*:

(Even though a cause of action for personal injuries cannot be split, a better rule would be that) a release procured by a tortfeasor, who is aware that the insurer claims to be subrogated to the rights of its insured, will not constitute a defense to the insurer's action against the wrongdoer to enforce its rights of subrogation. . . . By settling the insured's claim with knowledge of the insurer's interest, the tortfeasor was held to have consented to a separation of the cause of action.⁷²

However, the court added a caveat to this rule. The right of subrogation may be lost by delay or conduct on the part of the subrogee which can be construed as a waiver or estoppel. The subrogee may be barred if the subrogor settles with the tortfeasor before payment by the subrogee. The subrogee may be barred from proceeding against the tortfeasor or his insurer when in good faith and without notice of the subrogee's payment, he effectuates a settlement with the subrogor. And finally, the subrogee cannot recover from its insured *and* the tortfeasor or his carrier; he may recover from one or the other. These limitations are equitable and impose on the insurer the minimal duty of watching out for its own interest rather than placing that burden upon the insured, the tortfeasor, or the liability carrier.

B. *Other Insurance.*

The insurer may also attempt to recover payments made for medical expenses from another insurance carrier who provided liability protection, medical payments protection or Uninsured Motorist protection to the injured party or the tortfeasor.

⁷¹ *Id.*, 404 P.2d at 13. See also *Travelers Indemnity Co. v. Godfrey*, 12 Ohio Misc. 143, 41 Ohio Ops. 2d 166, 230 N.E.2d 560 (1967) where the subrogated insurance company was entitled to sue the tortfeasor in its own name to recover for medical payments made to its insured. In this case the fact that the defendant had settled with the injured insured was held not controlling.

⁷² 227 A.2d 105, 112 (R.I. 1967).

As previously indicated, the insurer should be permitted to recover its payments from any liability carrier of the tortfeasor, in a jurisdiction where subrogation provisions are valid. Whether it may directly sue the carrier is dependent upon compliance with the necessary party requirements and direct action statutes in force in the controlling jurisdiction.

The carrier may also attempt to recover from other carriers or plans providing medical expenses on behalf of the insured basing its rights upon one of two provisions in its policy or contract the "other insurance" provision or the subrogation provision. The scope of this article prohibits a discussion of rights under an "other insurance" provision or the validity of such a provision in a medical expense protection endorsement.⁷³

Whether or not a subrogated insurer or health plan would be entitled to recover from another carrier or plan providing similar benefits on behalf of the insured, solely on the basis of the subrogation provisions, has not been decided by any case uncovered in the research for this article. It would appear to this writer that such an attempt would be novel and unsuccessful. In order for the court to recognize such a right, it would have to hold that one party providing first party insurance benefits would be able to recover from another party who stands in the same shoes, without any reasonable distinction present to justify the apparent arbitrary result.

An interesting and as yet unanswered question is whether or not an insurer may seek reimbursement from the injured party's uninsured motorist carrier.⁷⁴ The purpose of the uninsured motorist endorsement is to compensate the insured for his personal injuries as if the uninsured motorist was in fact insured in accordance with the state financial responsibility law.⁷⁵ If the tortfeasor was insured, the insurer would

⁷³ For a discussion of such a provision see Pourous, Melendes and Craig, *Medical*

Payments Provision of the Automobile Insurance Policy: An Illustration of First Party Insurance Problems, 52 MARQ. L. REV. 445 (1969).

⁷⁴ Uninsured Motorist Protection coverage is a combination of first party and third party insurance protection. Generally speaking, this is an insurance which compensates its own insured for any and all personal injuries suffered as a result of the acts of an "uninsured motorist," i.e., generally, a defendant without liability protection. Many of the states have passed legislation requiring such insurance in all policies or requiring that it be offered to all policyholders. So. CAROLINA CODE OF LAWS § 46-750.14 (1962) [required to be in policy]; WIS. STAT. § 204.30(5) (1969) [only required to be offered]. For detailed examinations of "uninsured motorist" insurance see: R. Cox, *Uninsured Motorist Coverage*, 34 Mo. L. Rev. 1 (1969); *Symposium, The Uninsured Motorist Endorsement*, 53 MARQ. L. REV. 319 (1970).

⁷⁵ Because "uninsured motorist" protection provides benefits for many potential insureds under the definition of an "insured", several policies could also apply providing certain elements of personal injury, such as medical expenses. For example, a passenger in a car owned by B, being operated by A, is injured when such vehicle is struck in the rear by another vehicle operated and/or owned by one without liability protection. In such a case the injured party may be entitled to benefits for medical expenses under his own hospitalization-medical care plan such as Blue Cross-Blue Shield, in addition to being en-

be reimbursed for payments made to its insured for medical expenses. Should not the insurer be permitted to proceed against the uninsured motorist carrier? The author has found no reported case which has either decided or even considered the issue.

The uninsured motorist carrier's strongest argument is that its endorsement provides benefits to its insured—it is first party insurance—it does not provide any benefits on behalf of the tortfeasor. The rights which are transferred from the injured party to the medical expense insurer are only those which the insured could recover from the tortfeasor or one responsible for the acts of the tortfeasor. Subrogation under a medical expense or health care contract is not, and cannot operate as, an assignment of all rights and benefits accruing to its insured.

Therefore, the medical expense insurer is not entitled to any *other benefits* the insured may accrue because of his injuries. The carrier should not be entitled to benefit from a contract between principals entirely foreign to the subrogated carrier or health plan.

On the other hand, the subrogated party or carrier could contend that it is subrogated, not merely to the insured's rights against the tortfeasor, but to any rights the insured accrued as the result of injury caused by the acts of a third party. The rights acquired by the insured to compensation from an "uninsured motorist" carrier accrued as a result of the negligence of a third party. Therefore, the medical payments carrier or health plan has, to the extent of its payments, been substituted for its insured as beneficiary under an uninsured motorist endorsement.

In addition, the subrogated insurer can turn one of the arguments of the "uninsured motorist" carrier around. The insured has, by contract, shifted its rights under any policy providing protection from the negligence of another (on either third party beneficiary status or otherwise) to his medical expense insurer. The "uninsured motorist" carrier, who collected a premium for the benefits due the injured party, cannot escape liability under its contract as a result of a contract to which it was not a party.

Even though no case law exists, a court faced with this issue might base its decision on the principle that health insurers and pre-paid medical service plans are "primary insurers" and should not be permitted to recover from the "uninsured motorist" carrier who is a "secondary" insurer.

It is important to recall that in the majority of the states "uninsured motorist" protection must be offered as additional coverage in

titled to benefits under the automobile policies issued to A, or to B, both of which may contain an uninsured motorist endorsement.

automobile insurance policies issued in that state. In some states it is absolutely required, while in others it must be offered, but can be rejected by the insured in writing. It would seem then that it was not the intention of the various legislatures to protect third parties, but rather to protect those who attempt to insure themselves against loss caused by those who insist on being irresponsible. The public policy expressed in such legislation is that of protecting families from the financial disasters which automobile accidents can suddenly cause. It is accomplished by spreading the cost of injury among those in the community who own or operate motor vehicles by way of insurance programs. But since "uninsured motorist" coverage is very much in a sense "secondary" insurance, collectable only if the tortfeasor is not insured or if coverage is denied, it is likely that a court would be unwilling to permit a "primary" insurer to enforce its subrogation rights against the "uninsured motorist" insurance company.

That unwillingness to sanction recovery by primary insurers against "uninsured motorist" insurance coverage has been demonstrated in a number of cases in which the primary insurers involved were workmen's compensation carriers.

Of particular interest here is the following clause often found in uninsured motorist coverage provisions:

This insurance does not apply so as to insure directly or indirectly to the benefits of any Workmen's Compensation or disability benefits carrier or any person or organization qualifying as a self-insurer under any Workmen's Compensation or disability benefits law or similar law.⁷⁶

*Horne v. Superior Life Ins. Co.*⁷⁷ provides an illustration of the problem involved when a "primary" carrier attempts to enforce its subrogation rights against the Uninsured Motorist carrier. In *Horne* an employee's claim against his employer's compensation carrier was dismissed by the trial court because the employee, by settling with his "uninsured motorist" carrier, had destroyed the compensation carrier's subrogation rights against the "uninsured motorist" carrier. The Virginia Supreme Court reversed on the ground that the purpose of the uninsured motorist law was to provide additional protection to the insured, not to third parties. It said:

[The "uninsured motorist" insurer] does not stand in the shoes of . . . the uninsured motorist. . . . [Its] liability to the insured is contractual. . . . Mrs. Horne chose to provide . . . additional protection under the uninsured motorist for herself and others protected thereby and not the Superior . . . Superior's rights of subrogation are against . . . the alleged third party tortfeasor. . . .⁷⁸

⁷⁶ See: Monograph: *Uninsured Motorist Coverage*, DEFENSE RESEARCH INSTITUTE (1968).

⁷⁷ 203 Va. 282, 123 S.E.2d 401 (1962).

⁷⁸ *Id.*, 123 S.E.2d at 405.

Since the compensation carrier's subrogation rights did not include the benefits of the uninsured motorist protection afforded the employee, the employee did not destroy any rights of the compensation carrier. It is true, admitted the court, that the Workmen's Compensation Act provides that the employee shall not make a double recovery against the employer and the tortfeasor. However, Horne's first recovery was against the "uninsured motorist" insurer, not the tortfeasor, therefore, the employee was entitled to workmen's compensation benefits.

In *Commissioner of State Ins. Fund v. Miller*⁷⁹ a New York court denied the workmen's compensation carrier's subrogation rights against the "uninsured motorist" carrier on the theory that the insured had not recovered from the tortfeasor but had received payments from his "uninsured motorist" carrier, whose liability, although based in part on the contingency of a third party's tort liability, was merely contractual. The court acknowledged that the compensation carrier's right to a lien, created by statute, would remain unimpaired if the insured achieved a recovery from the tortfeasor and that it could sue the latter if the employee failed to act, but held that the compensation carrier was not entitled to the benefit of any insurance by which the employee might provide additional protection at his own expense.⁸⁰

An analogous situation occurs when a collision insurer which has paid the damages caused by the actionable negligence of an uninsured motorist commences subrogation proceedings against the uninsured motorist coverage carrier.

In *Motorist Ins. Corp. v. Surety Ins. Corp.*,⁸¹ it was held that the collision carrier was not entitled to be "indemnified" by the "uninsured motorist" insurance company. The court recognized that:

An action by an insurer who has paid a covered loss against a person whose tortious conduct caused the injury presents a clear case for subrogation. [However], an insurer, on payment of a covered loss, has no right of recovery against a third person merely upon proof that the insured could have recovered from such a person.⁸²

The court was impressed with the fact that the collision insurer collected a premium for its coverage while the uninsured motorist insurer was prohibited from collecting a premium for such coverage by state law. The court, therefore, concluded:

⁷⁹ 4 App. Div. 2d 481, 166 N.Y.S.2d 777 (1967).

⁸⁰ See Annot., 19 A.L.R.2d 1256 (1951). Were the compensation carrier's rights against the tortfeasor unimpaired? The standard uninsured motorist endorsement provides that in the event of payment under the endorsement, the insurer shall be subrogated to the rights of the insured against the tortfeasor. Are those subrogation rights in turn subject to the rights of the compensation carrier or are they equal to the rights of the compensation carrier?

⁸¹ 134 S.E.2d 631 (S.C. 1964).

⁸² *Id.*, at 632.

The purpose of the [Uninsured Motorist] Act was to relieve [an] insured motorist, within specified limits, of the risk of injury from the tortious conduct of financially irresponsible, uninsured motorist. . . . Nothing in the terms of the Act indicate the intention to relieve other insurers of primary responsibility for their own contractual obligations or to benefit them in any way.⁸³

The same question arose in *Bobbitt v. Shelby Mutual Ins. Co.*⁸⁴ where judgment had been rendered against the uninsured in one action, and the insured, on behalf of his collision carrier, brought suit against the "uninsured motorist" carrier. The latter denied liability because of a provision in its policy that the property damage coverage therein applied as "only excess insurance over any other valid collectable insurance of any kind." The court quoted from *Horne*:

"Here, [the uninsured motorist carrier] does not stand in the shoes of the . . . insured motorist. Its policy does not insure [the uninsured motorist] against liability. It insures [the insured] . . . against inadequate compensation."⁸⁵

The court, following *Motors Insurance Corp. v. Surety*,⁸⁶ held that the "uninsured motorist" carrier did not stand in the shoes of the tortfeasor, against whom the collision carrier did have a right of subrogation. It also held that while the Virginia Uninsured Motorists Act⁸⁷ required the uninsured motorist to pay to the insured all sums which he would be entitled to receive from the uninsured motorist, "[A]n insurer of the named insured was not defined as an 'insured' . . ."⁸⁸

There is another area involving the rights of a subrogee to recover from an 'insured motorist' carrier after it has paid the medical expenses of a party entitled to benefits under the "uninsured motorist" endorsement. This remaining area deals with the rights of the government under Federal medicare programs.

In *Government Employees Insurance Co. v. United States*⁸⁹ a serviceman's dependent was injured by an uninsured motorist. The insurer of the car in which the dependent was riding when injured made a settlement with him for personal injuries but refused to reimburse the federal government for the medical expenses it incurred on his behalf. The serviceman's uninsured motorist policy obligated the insurer "to pay all sums which the insured . . . shall be legally entitled to recover as damages from the owner or operator of an uninsured automobile." Further, the term "insured" under this provision was defined to include:

⁸³ *Id.*

⁸⁴ 209 Va. 37, 161 S.E.2d 671 (1968).

⁸⁵ 161 S.E.2d at 673.

⁸⁶ 134 S.E.2d 631.

⁸⁷ VA. CODE ANNOT. § 38.1-381 (1970).

⁸⁸ 161 S.E.2d at 674. *emphasis added.*

⁸⁹ 376 F.2d 836 (4 Cir. 1967).

- (b) any other person while occupying an uninsured automobile;
and
- (c) any person with respect to damages he is entitled to recover because of bodily injury to which this part applies sustained by an insured under (a) or (b) above.

Because the Federal Medical Care Recovery Act⁹⁰ provides that the federal government has an independent right to recover from a tortfeasor for medical expenses it pays, the Court held that the Federal Government met the requirement of (c) above. The court, as a result, concluded that the United States: "relies on that [Federal Medical Recovery] Act merely to establish its right to recover of the uninsured motorist . . . But it plants its right to recover upon the express language of the policy, which provides that one entitled to recover of the uninsured third party is in turn entitled to payment under the policy as an insured as defined in Sec. (c) . . ."⁹¹

By passage of the Federal Medical Care Recovery Act, the Federal Government was thus able to recover the expenses it incurred from an uninsured motorist carrier. This might serve as an example of legislation which medical carriers could urge state legislatures to enact for protection of their subrogated claims. Of course, such legislation is doubtful, as the federal government was serving its own self-interest in passing the Federal Medical Care Recovery Act, while state legislatures have no reason to favor private medical payments carriers over private uninsured motorist carriers, and it might appear particularly unjust to do so where state law requires that uninsured motorist coverage must be offered.

IV. DIVISION OF PROCEEDS BETWEEN SUBROGATED INSURER AND CLAIMANT

There are several practical problems concerning division of proceeds between the subrogated insurer and the individual claimant when a liable tortfeasor has limited financial responsibility or a liability insurance contract with applicable limits less than the total size of the claim or claims. Frequently both factors enter into the picture.

Pro-rating between a subrogated insurer and a claimant in comparative negligence states ought to be quite simple. Assuming a \$10,000 injury, a claimant 30% causally negligent, and an insurer subrogated to the extent of \$1,000, it would appear logical and fair that the subrogated insurer should receive from the proceeds of the judgment (or negotiated settlement) 70% of his claim (\$1,000 minus \$300—representing the proportionate share of comparative negligence) which equals \$700. In the opinion of the writer this is the clearly applicable law and the generally accepted practice in comparative negligence states.

⁹⁰ 42 U.S.C. § 265(a).

⁹¹ 376 F.2d at 847.

The subrogated insurer scales its recovery downward in the same proportion that its insured must scale down his recovery.

Unfortunately, in Wisconsin in a 1932 decision, *Patitucci v. Gerhardt*,⁹² it was contended that the acceptance of part payment from the collision insurer operated as an assignment "pro tanto" of the plaintiff's cause of action. Many health and accident insurers have argued the phrase "pro tanto" means that on any recovery the subrogated insurer receives the entire proceeds up to the amount of its subrogation claim. While it is difficult to perceive how a more inequitable treatment could be afforded to the individual insured, this writer knows of many cases where settlement has been negotiated based on this principle. The majority of settlements, however, proceed on the basis of a pro rata distribution of funds between the subrogated insurer and its insured. While this writer knows of no specific cases on the subject it is his opinion that if litigated this would be the result in all the jurisdictions studied.

In states in which contributory negligence bars recovery, theoretically, the problem of distribution between the subrogated insurer and its insured does not exist. Obviously if there is liability for the medical expenses, there also would be liability for the personal injuries. Any recovery, therefore, would pay to the subrogated insurer the entire amount of its medical expenses.

As a practical matter, however, a principle very similar to the applicable rule in comparative negligence states applies. Assuming \$1,000 of medical expenses in a personal injury case reasonably worth \$10,000 with the likelihood of recovery in the area of 70% for the plaintiffs, a negotiated settlement at \$7,000 would result in additional negotiations between the subrogated insurer and its insured with equitable distribution of the proceeds in an amount of \$6,300 to the individual claimant and \$700 to his subrogated insurer.

Experienced trial counsel will immediately realize, however, that upon trial this equitable result probably will not be the case.

As a practical matter there are very few damage defenses better than a close liability question. In states in which contributory negligence bars recovery, therefore, the trial of a 70-30 potential liability case might well result in recovery for the plaintiff, but with a somewhat diminished damage award. If the case were tried successfully for the claimant, it would mean that the subrogated insurer would receive 100% of its expended funds, and this realistic analysis is frequently exploited on behalf of subrogated insurers when negotiating settlements with its insureds in these states.

⁹² 206 Wis. 358, 240 N.W. 385 (1932).

Where the liable tortfeasor has limited financial resources through insurance or otherwise, it would appear that the most equitable manner of distribution of proceeds by settlement or after judgment between the subrogated insurer and the individual insured would be on a pro rata basis.

In the administration of subrogation claims for H & A carriers this is a frequently occurring problem. Claimant (often a non negligent, guest passenger) incurs severe personal injuries with a reasonable jury verdict value of \$100,000. It develops, however, that the individual defendant is not financially responsible and the applicable limits of liability on his auto insurance policy is \$10,000 for any one person injured in any one accident. The subrogated insurer has paid \$10,000 for hospital and medical expenses. The equitable rule (although there are few cases on it) would distribute the \$10,000 of available proceeds \$9,000 to the insured and \$1,000 to the subrogated insurer.

A 1967 New Jersey case⁹³ considered this issue. Germer was riding in Root's car and was injured when struck by a car negligently driven by Stallone. Germer received \$2,000 in medical payments from Root's insurer. Germer brought action against Stallone and Root. The jury absolved Root of negligence and assessed the entire negligence against Stallone. A judgment was entered for Germer's injuries for \$60,500. Stallone's insurance had a \$10,000 policy limit. Root's insurer maintained that it should receive back, out of the \$10,000 of proceeds under its subrogation clause the entire \$2,000 that it had expended. The court ruled against the insurer saying: "Since she only received approximately one-sixth of her judgment in this proceeding, equitable principles compel the court to conclude that Seaboard (the insurer) recover one-sixth of the \$2,000, or \$333 . . ."⁹⁴ The court noted that it was unable to find any cases supporting this position. The writer believes, however, that it should be the universally accepted rule.⁹⁵

An analogous situation involving fire insurance occurred in *Pontiac Mutual County Fire and Lightning Insurance Co. v. Sheibley*.⁹⁶ Sheibley's farm, insured by Pontiac Mutual for \$800, was completely destroyed by fire caused by a railroad company's negligence. Sheibley obtained a \$4,000 verdict against the railroad. It appealed and a settlement ultimately was negotiated at \$3,000. Pontiac demanded from Sheibley a pro rata share of the proceeds, that is, three-quarters of what it had paid Sheibley on the theory that he recovered three-quarters of the damages as assessed by the jury. Sheibley, however, refused to

⁹³ *Germer v. Public Service Mut. Ins. Co.*, 99 N.J. Super. 137, 238 A.2d 713

⁹⁴ *Id.*, 238 A.2d at 717.

(1967).

⁹⁵ See also, *Blue Cross of Florida v. O'Donnell*, 230 So.2d 706 (Fla. 1970 [implying same result as in *Germer*]).

⁹⁶ 279 Ill. 118, 116 N.E. 644 (1917).

pay, saying that since all his losses as determined by the jury had not been recovered, the insurance company was not entitled to reimbursement. The court ruled in favor of Pontiac. The Illinois Supreme Court, noting that Pontiac had offered to help in the appeal, affirmed saying that Pontiac was entitled to its pro rata share of the proceeds of the negotiated settlement.

On occasion a further complication arises when the subrogated insurer has not paid the entire amount of the hospital and medical charges either because of limitations in its policy or because it feels treatment was not reasonable and necessary for the injuries incurred. There are no reported decisions directly ruling in this area, but practical administration would favor an equitable distribution on a pro rata basis taking the entire amount of the insured's claim (for personal injuries, wage loss, or uncompensated medical expense) as compared with the amount of the claim of the subrogated insurer. This problem is more easily manageable in jurisdictions that permit separate answers to the damage questions in a special verdict where the question of reasonableness and necessity of expenditures for medical expenses is raised.

V. RIGHT OF ATTORNEY TO COLLECT FEES FROM SUBROGATED INSURER

In many instances where the injured party brings suit against the tortfeasor, the subrogated insurer or prepaid medical expense organization will not take its own legal action—rather it will merely give notice of its subrogation interests. These claims may or may not be recognized, however, in most cases they are, and insurers recover their payments from the settlement fund or judgment rendered. The question then arises as to whether or not the insurer may recover the full amount, or whether an amount must be deducted for expenses incurred in obtaining the recovery including attorney's fees.

The following hypothetical will illustrate some of the problems facing the attorney representing the injured party, the insured party, and the insurer.

John Jones is injured in an automobile accident caused by the negligence of Bill Smith. As a result of the accident, John has incurred medical expenses amounting to \$1,500.00, which are paid by the XYZ insurance company under a "medical payments" endorsement which includes a subrogation provision. John then hires an attorney, George Thomas, agreeing to pay Mr. Thomas a 1/3 contingent fee in the event of trial.

After a jury awards \$6,000.00 to Jones, XYZ Insurance Company, which expended \$1,500 for Jones' medical expenses pursuant to the medical payments coverage in his automobile insurance policy, claims it is entitled to a return of \$1,500 because of its subrogation provision

in the policy. Thomas, who has handled the case for Jones on a 1/3 contingent fee basis, contemplates a number of possible ways of dividing the award.

- (1) Jones returns \$1,500 to XYZ, gives 1/3 of the remaining \$4,500 to Attorney Thomas (\$1,500), and keeps \$3,000 for himself;
- (2) Attorney Thomas gets 1/3 of the entire recovery (\$2,000), XYZ receives its \$1,500 in full, and Jones is left with only \$2,500;
- (3) Attorney Thomas gets 1/3 of the entire recovery (\$2,000), and Jones returns the \$1,500 to XYZ but deducts a reasonable amount for attorney's fees;
- (4) Attorney Thomas takes \$500, or 1/3 for the amount to be returned to the insurer, and an additional \$1,500 from the \$4,500 which is to go to Jones.

The problem must first be considered in light of the generally held view that the mere fact that the services an attorney renders for his client are beneficial to other parties does not entitle the attorney to recover any compensation from those also benefited.⁹⁷ It is also generally held that the client who has engaged an attorney and paid his fees is not usually entitled to recover a proportionate share of the attorney's fees from those who may receive a benefit from the service.⁹⁸

In addition, it should be remembered that the initial agreement for attorney's fees is worked out only by the injured party and the attorney. Thus, most claims by the subrogee, under the above law and facts, would not be subject to attorney's fees. Either the attorney or the injured client will have to take the loss. However, the majority rule in regard to fees due an attorney as a result of obtaining recovery for his client's subrogated insurer imposes some obligation on the insurer.

Because "medical payments" protection with subrogation is a relatively new item in insurance packages, and only recently included in health care contracts, only a few jurisdictions have had the opportunity to consider a dispute over attorney's fees.⁹⁹ Medical expenses are not, in reality, unliquidated damages such as pain and suffering, but rather they are specific and definite, thus separable from the general damages awarded for personal injury.

Because medical expenses are liquidated, the courts have relied upon and have treated the claim for legal fees the same as in other

⁹⁷ 7 AM. JUR. 2d, *Attorneys at Law* § 205. See also, *Eckford v. Atlanta*, 173 Ga. 650, 160 S.E. 773 (1931); 7 C.J.S., *Attorney and Client* § 175.

⁹⁸ 7 AM. JUR. 2d, *Attorneys at Law* § 205; see also: *Louisiana and N.W.R. v. Athens Lumber Co.*, 134 La. 788, 64 So. 714, (1914); *Christian Women's Benev. Assoc. v. Atlanta Trust Co.*, 181 Ga. 576, 183 S.E. 551 (1936).

⁹⁹ For a general discussion of this issue, see Annot., 2 A.L.R.4d 1441.

cases concerning subrogation of other various damages, such as collision, fire and workmen's compensation.¹⁰⁰

Where an insurer, underwriting a fire risk, perfects his subrogation rights by a recovery resulting solely from the efforts of the insured's legal counsel the more widely adopted rule is that the insurer must contribute a "proportionate" or "reasonable" share of the attorney's fees.¹⁰¹ However, such obligation is not absolute. In *Cary v. Phoenix*,¹⁰² the insurers underwriting the fire loss risk were not required to contribute to the attorney's fees because it appeared that the insured had assigned her entire interest in the recovery to her attorney in order to defraud the carriers. Had the action against the tortfeasor been prosecuted in good faith, for the benefit, wholly or in part, of the insurance companies, the court indicated that the insurers might have been required to contribute toward the expenses of the action.

Nor is an insurer underwriting the fire loss risk required to contribute toward the attorney's fees where the insurer has actively participated in the preparation and trial of the case.¹⁰³

Automobile insurers generally have been permitted to recover for property damage as subrogees where they have paid the insured's property loss under the "collision" endorsement. However, they have also been required to share the expenses of attorneys fees where their insureds initiated recovery.¹⁰⁴

United Services Auto Association v. Hills,¹⁰⁵ the leading case concerning the duty of the insurer to contribute to attorney's fees, involved a case where the insured's attorney was advised by the insurer, United, to delete the insurer's subrogation claim from the insured's suit against the tortfeasor. The attorney refused asserting if he deleted such claim, then the insured's action could be dismissed because of the prohibition of splitting a cause of action. A settlement between the tortfeasor's insurer, which had been notified by United of its interest and

¹⁰⁰ Generally, the compensation carrier has been required to pay a portion of the employee's cost and expenses, including a portion of the attorney's fees. See LARSEN, WORKMEN'S COMPENSATION § 4:32 (1965).

¹⁰¹ *Brown v. T. W. Phillips Gas & Oil Co.*, 105 F. Supp. 479 (D.C. Pa. 1962) ["proportionate"]; *Suea Assurance Co. v. Packham*, 92 Md. 464, 48 A. 359, 52 L.R.A. 95 (1901).

¹⁰² Conn. 690, 78 A. 426 (1910).

¹⁰³ *Pontiac Mut. County Fire and Lightning Ins. Co. v. Sheibley*, 279 Ill. 118, 116 N.E. 644 (1917).

¹⁰⁴ *State Farm Mut. Auto. Ins. Co. v. Elkins*, 451 S.W.2d 528 (Tex. 1970); *Krause v. State Farm Mut. Auto. Ins. Co.*, 184 Neb. 588, 169 N.W.2d 601 (1969); *aff'd on rehearing*, 184 Neb. 639, 170 N.W.2d 882 (1969); *Washington Fire & Marine Ins. Co. v. Hammett*, 237 Ark. 954, 377 S.W.2d 811 (1964); *Forsyth v. Southern Bell Tel. Co.*, 162 So. 2d 916 (Fla. App. 1964); *Tennessee Farmers Mut. Ins. Co. v. Pritchett*, 54 Tenn. App. 410, 391 S.W.2d 671 (1964); *United Service Auto Assoc. v. Hills*, 172 Neb. 128, 109 N.W.2d 208 (1961). *But see*, *State Farm Mut. Auto. Ins. Co. v. Robbins*, 237 So. 2d 208 (Fla. App. 1970); *First of Georgia Ins. Co. v. Horne*, 120 Ga. App. 379, 170 S.E. 2d 452 (1969).

¹⁰⁵ 172 Neb. 128, 109 N.W.2d 174 (1961).

had agreed to protect United's rights, and the insured was reached as a result of the work of the attorney. United then brought a declaratory judgment action seeking to determine the validity of the attorney's claim for 1/3 of the amount that was to go to United. The court held that since the subrogation claim had to be brought in the insured's suit, considerations of justice and equity required that United pay the fees.

In *Krause v. State Farm Mutual Auto Ins. Co.*¹⁰⁶ the Nebraska Supreme Court held that the sum recovered by the insured in a suit against a tortfeasor (or agreed upon as settlement) was in the nature of a trust to the extent of the collision carrier's subrogation interests. Therefore, the court stated, that the right to a fee by the insured's attorney follows as a matter of course, since the services rendered by the attorney were beneficial to the administration of the trust and the right of the beneficiary.

Although the attorney was entitled to a fee to be paid out of the proceeds distributed to the insurer, what that fee should be was not determined. The case was remanded with an order for a new trial on the issue of what amount would fairly compensate the attorney for the services rendered the trust. The court then laid down the following guidelines for the trial court:

We do not hold in this case that State Farm is bound by the contract for fees between the plaintiff's attorney and the insured in the action against the tortfeasor. The allowance depends upon consideration of all these circumstances including the nature of the contract with the insured and the amount and the nature of the services rendered, and the other principles relating to the award of attorney's fees under the law.¹⁰⁷

*First of Georgia Ins. Co. v. Horne*¹⁰⁸ is typical of the minority rule which does not require the insurer to contribute to the attorney's fees. In this case the court maintained that the relationship of the attorney and client is a contractual one, and since there was no express contract of employment between the attorney and the subrogated insurer, the attorney was held to be a mere volunteer not entitled to a fee for the amount of the insurer's subrogation interests.

At least one state, in determining whether or not the insurer must contribute, has distinguished a subrogation agreement from a "loan receipt" executed by the insured at time of payment for his property loss. In *State Farm Mutual Auto Ins. Co. v. Robbins*,¹⁰⁹ an attorney's right to claim a fee from a collision carrier was denied, whereas in *Forsyth v. Southern Bell Tel. Co.*¹¹⁰ the court permitted the attorney

¹⁰⁶ 184 Neb. 588, 169 N.W.2d 601 (1969); *aff'd on rehearing*, 184 Neb. 639, 170 N.W.2d 882 (1969).

¹⁰⁷ *Id.*, 9 N.W.2d at 604.

¹⁰⁸ 120 Ga. App. 379, 170 S.E.2d 452 (1969).

¹⁰⁹ 237 So. 2d 208 (Fla. App. 1970).

¹¹⁰ 162 So. 2d 916 (Fla. App. 1964).

to deduct his fees from the proceeds accruing to the benefit of the subrogated insurer. In *Forsyth* the insurer had obtained a "loan receipt" from the insured. In *Robbins* the court argued that the "loan receipt" did not give rise to a separate cause of action, so that its interest was and could only be served by suit brought by the insured's attorney. However, in the case before it, State Farm had notified the insured's attorney that it would proceed alone for its subrogation interests and could do so because it had obtained a "subrogation receipt," which purported to give the insurer a separate cause of action. Having ignored State Farm's notice that it would proceed separately, the attorney was not entitled to deduct an amount for fees. The attorney could not even recover in quantum meruit since, said the court, "State Farm received no benefit from the Appellees from the work performed in the suit . . ." ¹¹¹

In most jurisdictions the right of the employer or workmen's compensation carrier to be subrogated to the rights of the injured employee is statutory. In some instances the statutes even set out the method in which the proceeds are distributed, first permitting the attorney to deduct his fee on the total amount recovered, then specified portions of the remainder are distributed to the employer or carrier and the employee. ¹¹² In other jurisdictions, the statutes are not specific on distribution. In such jurisdictions, the court determines an equitable distribution.

An interesting decision is *Commercial Union Ins. Co. v. Scott*. ¹¹³ Scott was retained by an employee of Commercial's insured to recover from the tortfeasor losses sustained by the employee. Scott arranged a settlement with the tortfeasor and forwarded a check to Commercial for the amount it had paid the injured employee along with a statement of fees amounting to 1/3 of the subrogated amount. The court denied the right of the attorney to claim any fee from the subrogation recovery:

The fact that the defendant was benefited by the plaintiff's services in obtaining a settlement does not make it liable for the plaintiff for such incidental benefits. Plaintiff's motive for suing the third party tortfeasor, it must be assumed, was to obtain an adequate recovery for his own client, and, thereby an attorney's fee for himself, rather than to obtain reimbursement for the defendant. ¹¹⁴

¹¹¹ *State Farm Mut. Auto. Ins. Co. v. Robbins*, 237 So. 2d at 210.

¹¹² WIS. STAT. § 102.29(1) (1969):

[The] liability of the tortfeasor shall be determined as to all parties having a right to make a claim, and irrespective of whether or not all parties join in prosecuting said claim, the proceeds . . . shall be divided as follows: After deducting the reasonable cost of collection, one-third of the remainder shall in any event be paid to the injured employee. . . . out of the balance remaining, the employer or insurance carrier shall be reimbursed for all payments made by it or which it may be obligated to make. . . . Any balance remaining shall be paid to the employee. . . .

¹¹³ 116 Ga. App. 633, 158 S.E.2d 295 (1967).

¹¹⁴ *Id.*, 158 S.E.2d at 297.

Although the insurer was to receive full reimbursement from the injured party, the attorney was entitled to collect his contingent fee from the entire sum which had been obtained by settlement with the tortfeasor rather than merely the amount to which his client was entitled.

In addition to the cases arising out of workmen's compensation the issue of attorney fees has been raised in several recent medical expense subrogation cases. These cases involve property loss by fire or collision.

In *Bradford v. American Mutual Liability Ins. Co.*¹¹⁵ the court ruled against an insured who brought suit against his insurer to recover the legal fees incurred in recovering his medical expenses from the tortfeasor. The insured had settled with the tortfeasor just eight days after sending a claim for medical expenses to the insurer. Since the insurer had not made any claim to the funds recovered from the tortfeasor (although once it had paid the medical expenses it would have had a right to subrogation under the policy), had not denied liability for the medical payments, nor engaged in delaying tactics, the insurer was not liable for any portion of the costs of procuring the settlement from the tortfeasor.

An attorney's claim to a fee from the insurer which had obtained a "loan receipt" from its insured after paying medical expenses was denied in *Courtney v. Birdsong*.¹¹⁶ The court in *Courtney* held that the sum which the insurer had expended for medical payments was the sum which the insured had agreed to reimburse the insurer, and that since the insurer had not agreed to pay the attorney a fee it need not do so.

Minnesota has indirectly permitted the insured to recover a portion of his costs of procuring a settlement or recovery against the tortfeasor. In *National Union Fire Ins. Co. v. Grimes*¹¹⁷ the insured refused to reimburse the insurer after recovering from the tortfeasor although the insurer had a valid claim under the subrogation provision in the policy. The insurer was entitled to reimbursement, said the court, but went on to say:

[The insured is] entitled to off-set against the \$970.20 received by him from the plaintiff, the reasonable worth and value of the efforts expended and expenses incurred by the defendant properly chargeable to that portion of the recovery from [the tortfeasor] attributable to those medical expenses . . . The amount of such an off-set is for determination by the trial court.¹¹⁸

The Wisconsin Supreme Court has recently rendered what may be the new leading case in this area—*State Farm Mutual Auto. Ins. Co. v. Geline*.¹¹⁹ In addition to adopting the majority position allowing at-

¹¹⁵ 245 A.2d 428 (Pa. Super. 1968).

¹¹⁶ 437 S.W.2d 238 (Ark. 1969).

¹¹⁷ 278 Minn. 45, 153 N.W.2d 152 (1967).

¹¹⁸ 153 N.W.2d at 156.

¹¹⁹ 48 Wis. 2d 290, 179 N.W.2d 815 (1970).

torney's fees, the *Geline* case set out specific procedures that must be followed by the insured's attorney before a claim can be made. It seems both practical and consistent with an attorney's ethical rule not to represent a client without specific authorization.

In this case both State Farm and Associated Hospital Services, Inc. (AHS), pursuant to provisions in the respective policy and contract containing subrogation clauses, paid part of the medical expenses of their insureds who were injured in an automobile accident. The accident allegedly was caused by Bauke, who was insured by Allstate Ins. Co. The Conovers consulted and retained Geline to represent them in an action against Bauke and his carrier, Allstate. The retainer agreement between Geline and Conovers set as fees, the standard contingency agreement used in Wisconsin. In essence the contingency contract provided that the attorney's fee would be equal to 25% of the recovery on behalf of the clients if the claim was settled prior to commencement of suit, 33-1/3% after commencement of suit and 40% after appeal.

The Conovers, by their attorney, commenced the action, but settled with Allstate and Bauke prior to trial. However, prior to the settlement both AHS and State Farm gave notice to Allstate of their subrogation rights and the amount of their claims. Allstate, however, ignored such notices and entered into a settlement agreement—putting the amount in escrow subject to a determination of rights between the Conovers and Geline as against AHS and State Farm. Geline claimed that he was entitled to 1/3 of each subrogation claim since he had procured the settlement fund. The two subrogated parties then brought a declaratory judgment action. The trial court found that Geline was entitled to a 1/3 fee of each subrogation claim.

On appeal, the Wisconsin Supreme Court stated that Geline was not entitled to the 1/3 fee from the insurers since there was no reason to hold that Geline was retained by the Conovers to collect from or for State Farm and/or AHS. However, the court accepted the "fund doctrine" (the majority rule) and held that: An attorney rendering service in creating a trust may in equity be allowed compensation out of the whole fund from those who directly benefit from its accumulation.¹²⁰

The court, in adopting the "fund" doctrine stated that such doctrine had superior merit in equity than that proposed by the subrogated parties. However, the court, in adopting the more equitable doctrine, placed strict restrictions on its use, and thereby created a procedure which can readily be followed by either the attorney or the subrogated parties. These restrictions are as follows:

¹²⁰ *Id.* at 298, 179 N.W.2d at 819.

(1) *Creation of fund.*

The fund has to be brought into being solely by the efforts of the attorney who is claiming an equitable right to the fees therefrom.

(2) *Notice.*

Notice has to be given the holders of subrogated interests, *not only that an action has been commenced but also that, unless the holder elects to join in the action as a party thereto, a reasonable fee for services rendered in accomplishing the collection of its subrogated interest will be requested of the court in any settlement or court disposition.*

(3) *Joinder.*

The "fund doctrine" only applies where the holder of a subrogated right does not become a party to the lawsuit.

The majority rule appears to be that the subrogated insurer or pre-paid medical expense plan must respond and compensate its insured's costs (including attorney's fees) when the insured's efforts have resulted in recovery from the tortfeasor.¹²¹ However, the amount which the insured's attorney is to be compensated—or the amount of reimbursement is not dependent on the contract between the insured and the attorney, but is to be a reasonable amount for the services rendered.¹²²

The court rejected the "proportionate share" award of the trial court, stating that this type of "measuring stick" makes the agreement between the insured and his attorney the sole determinative of the "reasonableness" of the fee. Therefore, the court remanded the action to the trial court to take testimony and determine what a reasonable fee would be based upon all of the circumstances keeping the following in mind:

- (1) Nature of the contract with the insured;
- (2) Amount of services rendered; and
- (3) Degree of difficulty of establishing liability.

The reasonable fee doctrine does not necessarily mean that in all circumstances the contingent fee percentage agreed upon by the insured and his attorney cannot be used as the measure of a proper fee for the attorney to receive from the insurer. Canon 13 of the American Bar Association's Canons of Professional Ethics¹²³ points out that a contingent fee should be reasonable and that its reasonableness should be subject to the supervision of a court. The insurer's claim carries the same risk of uncertainty as the insured's claim. Therefore, it would seem that where the court approves the contingent fee agreed upon by

¹²¹ *E.G.*, *Brown v. T. W. Phillips Bas and Oil Co.*, 105 F. Supp. 479 (D.C. Pa. 1962); *Krause v. State Farm Mut. Auto Ins. Co.*, 184 Neb. 588, 169 N.W.2d 601 (1969), *aff'd on rehearing*, 184 Neb. 639, 170 N.W.2d 882 (1969).

¹²² *State Farm Mut. Auto Ins. Co. v. Geline*, 48 Wis. 2d 290, 179 N.W.2d 813.

¹²³ AM. JUR. 2d, *Desk Book*, p. 226 (1962).

the attorney and the insured, the same fee would be reasonable as to the insurer.¹¹⁹ An argument could be made that proving the special damages for medical expense takes less imagination and talent than obtaining a large award for pain, suffering and permanent disability.

However, since the insurer is, for all practical purposes, bound by the choice the insured makes in selecting his attorney, and is unable to enter as a participant in the negotiations for the fee to be charged, the court may be reluctant to bind the insurer to return to the attorney the same percentage of its recovery which the insured has agreed to return.¹²⁴ Canon 12 of the Canons of Ethics cites the following as factors to be considered in determining the amount of an attorney's fees:

- (1) The time and labor required, the novelty and difficulty of the questions involved and the skill requisite properly to conduct the cause;
- (2) Whether the acceptance of employment in the particular case will preclude the lawyer's appearance for others in cases likely to arise out of the transaction and in which there is a reasonable expectation that otherwise he would be employed, or will involve the loss of other employment while employed in the particular case or antagonisms with other clients;
- (3) The customary charges of the Bar for similar services;
- (4) The amount involved in the controversy and the benefits resulting to the client from the services;
- (5) The contingency or the certainty of the compensation; and
- (6) The character of the employment whether casual or for an established and constant client.¹²⁵

VI. DIVISION OF PROCEEDS WHERE MULTIPLE SUBROGATED INSURERS SEEK RECOVERY

A particularly difficult problem is presented when a number of subrogated insurers seek recovery from the proceeds of a personal injury settlement or judgment. Although the situation occurs frequently, there are as yet no reported decisions.

The typical case involves a claimant in a personal injury accident who is employed by a manufacturer with a health and accident insurance contract for medical expenses containing a subrogation clause. The claimant also has a medical payments clause in his own liability insurance contract so that he becomes entitled to payment for his medical expenses both from the health and accident insurer and his liability

¹²⁴ See *United Services Auto Assoc. v. Hills*, 172 Neb. 128, 199 N.W.2d 174 (1961).

¹²⁵ AM. JUR. 2d, *Desk Book*, p. 225 ((1962)). Counsel for AHS had proposed prior to the new trial, that these factors be determining. However, AHS settled with Mr. Geline prior to trial. State Farm took an interesting approach rather than return to the trial court which had already held a "reasonable" fee would be 1/3 of the subrogation claims. State Farm and Geline submitted their dispute to a panel of three arbitrators picked by the Milwaukee County Bar Association.

insurer under its medical payments provisions. Assume \$1,000 in medical expenses for which claimant receives a check from his H & A carrier, and a check from the medical payments insurer. He subsequently obtains a \$10,000 recovery from the negligent tortfeasor's insurer and both the H & A carrier and medical payments carrier demand reimbursement under their respective subrogation clauses. Obviously, of the \$10,000 recovery from the liability insurer of the negligent tortfeasor, only \$1,000 is attributable to the medical expense for which the claimant has already been reimbursed twice. Is each subrogated insurer entitled to its \$1,000 back or should the subrogated insurers divide the \$1,000 attributable to the medical expenses? The problem becomes even more involved where the claimant has paid some medical expenses himself due to limitations in the respective first party contracts or a claim that the treatment was not reasonable or necessary.

There are no reported cases but the answer to the division of proceeds between the first party insurers probably turns on the particular theory on which the state permits subrogation recovery. As indicated in Appendix A, many states proceed on the theory that denying a double recovery to a claimant is a fair and equitable result. While it is true a claimant should be able to contract for such recovery should he so desire, having contracted for first party coverage with two insurers where both include a subrogation clause, claimant should be held to his negotiated agreement and the subrogated insurers should both be entitled to recover.

On the other hand, in those states that proceed on a strict assignable interest theory (or some deviation thereof), the assignment would only be for the proceeds of the medical expenses, and therefore, since they are recoverable but once from the negligent tortfeasor's insurer, the recovery should be divided pro rata between the subrogated insurers.

As to those states whose theory of permitting subrogation recoveries presents a highbred or combination of reasons, no firm or fixed answer to the problem can be suggested.

VII. MISCELLANEOUS PROBLEMS

There are miscellaneous practical problems related to subrogation clauses where the amounts involved seldom justify litigation but where the ingenuity of claimants and counsel presents some fascinating theoretical problems.

Certainly no subrogation clause can be intelligently administered or enforced by an insurer without an accompanying obligation on the insured to cooperate with his insurer. Where the insured can profit from some form of non-cooperation, however, peculiar results follow.

In almost all the states a husband is primarily responsible for medical expenses of his wife incurred in a personal injury accident. In

most of the states, however, a wife can make herself primarily liable by indicating, at the time of admission for treatment, that she will assume primary liability. This can make quite a difference.

The case of a husband, employed by a manufacturer with a health and accident insurance contract providing coverage to the husband and his dependents, whose wife is seriously injured when the vehicle her husband is driving leaves the highway and strikes a tree will serve as an example. In those states that do not bar guests' actions against their host, or a wife's action against her husband, it is clear that the wife has a personal injury claim against her husband for pain, suffering and permanent disability. But what about the medical expenses? If the wife upon entry to the hospital and upon receiving treatment from the physician indicates she will become primarily liable, she thereby creates a claim for the medical and hospital expenses in herself. In this manner she can proceed against her husband's liability insurer for those expenses whereas they would otherwise be the husband's claim and would be extinguished by his being the sole tortfeasor.

What happens, however, where the wife is insured through her place of employment and that insurer pays the medical expenses on her behalf. Does that fact represent an assumption by her (actually her subrogated insurer) of primary liability for the hospital expenses thereby entitling her subrogation insurer to collect from the liability carrier of the husband? This is a frequently raised question especially where the wife is unconscious upon her arrival at the hospital. This problem has become more common as additional women have entered the work force and have acquired the same fringe benefits as their husbands.

Another common problem arises when a minor plaintiff is injured and the adverse liability insurer negotiates a settlement with the plaintiff and his father, who is by law primarily responsible for the injured child's medical expenses. Many settlements are negotiated on the basis of the top dollar going to the injured minor with a very minimal amount awarded (with court approval) to the injured child's father for ultimate theoretical distribution to the subrogation insurer. Certainly that insurer has the right to proceed independently but as a practical matter its chances of success are negligible in a close case where its subrogation claim is not presented along with the claim for personal injuries and permanent disability of the injured child. The number of court orders entered in minor court settlements practically closing out the rights of subrogated insurers to the medical expenses are almost limitless.

Appendix A — Subrogation Clauses

State	Validity	Theory	Case
Alabama	Undecided	*	* <i>Harleyville Mut. Ins. Co. v. Lea</i> , 2 Ariz. App. 538, 410, P. 2d 495 (1966) <i>Shibley v. Northwest Mut. Ins. Co.</i> , 224 Ark. 1159, 428 S.W. 2d 268 (1968) <i>Courtney v. Birdsong</i> , 437 S.W. 2d 238 (1968) <i>Sentry Ins. Co. v. Stuart</i> , 439 S.W. 2d 797 (1969) <i>Black v. California Physicians Service</i> , 53 Cal. Rptr. 51 (1966) <i>Dodds v. Bucknum</i> , 214 Cal. App. 2d 206, 28 Cal. Rptr. 393 (1963) <i>Camizo v. Guarantee Ins. Co.</i> , 53 Cal. Rptr. 637 (1966)
Alaska	Undecided	*	
Arizona	Invalid	Assignment of tort action	
Arkansas	Valid	Subrogation different from assignment	
California	Invalid, but Lien theory valid	Lien theory—denial of double recovery as inequitable	* <i>L'Menian v. American Motorists Ins. Co.</i> , 4 Conn. Cir. 524, 236 A. 2d 349 (1967) <i>Elkblade v. Anderson</i> , 28 Conn. Supp. 177, 255 A. 2d 885 (1969) <i>Yarrington v. Thornburg</i> , Del. Sup. Ct., 198 A. 2d 1 (1964) <i>Adams v. Turner</i> , 238 F. Supp. 643 (1965) <i>DeCespedes v. Prudence Mut. Cas. Co.</i> , 193 So. 2d 224, <i>Aff'd</i> 202 So. 2d 561 (1967) <i>Shelby Mut. Ins. Co. v. Birch</i> , 196 So. 2d 428, <i>Aff'd</i> 202 So. 2d 561 (1967) <i>Maryland Cas. Co. v. Plant</i> , 208 So. 2d 280 (1968) <i>Wrightman v. Hardware Dealers Mut. Fire Ins. Co.</i> , 147 S.E. 2d 860 (1966)
Colorado	Undecided	*	
Connecticut	Valid	Denial of double recovery as inequitable	
Delaware	Valid	Denial of double recovery as inequitable	
District of Columbia	Valid	Denial of double recovery as inequitable	* <i>Smith v. Idaho Hospital Service, Inc.</i> , 89 Ida. 499, 406 P.2d 696 (1965) <i>Bernardini v. Home and Auto Ins. Co.</i> , 64 Ill. App. 2d 465, 212 N.E. 2d 499 (1965) <i>Danihesel v. Hardware Dealers Mut. Fire Ins. Co.</i> , 60 Ill. App. 2d 279, 209 N.E. 2d 877 (1965) <i>State Farm Mut. Auto Ins. Co. v. Mid-Century Ins. Co.</i> , 259 N.E. 2d 424 (Ind. App. 1970)
Florida	Valid	Subrogation different from assignment	
Georgia	Invalid	Assignment of tort action	
Hawaii	Undecided	*	
Idaho	Valid	Double recovery denied as inequitable	* <i>Smith v. Idaho Hospital Service, Inc.</i> , 89 Ida. 499, 406 P.2d 696 (1965) <i>Bernardini v. Home and Auto Ins. Co.</i> , 64 Ill. App. 2d 465, 212 N.E. 2d 499 (1965) <i>Danihesel v. Hardware Dealers Mut. Fire Ins. Co.</i> , 60 Ill. App. 2d 279, 209 N.E. 2d 877 (1965) <i>State Farm Mut. Auto Ins. Co. v. Mid-Century Ins. Co.</i> , 259 N.E. 2d 424 (Ind. App. 1970)
Illinois	Valid	Lien theory— subrogation not assignment	
Indiana	Valid (Dicta)	Subrogation clause not ruled invalid	

State	Validity	Theory	Case
Iowa	Undecided	*	*
Kansas	Undecided	*	*
Kentucky	Undecided	*	*
Louisiana	Valid	Double recovery denied as inequitable	<i>Hawkeye v. Simmons</i> , 91 So. 2d 49, 61 A.L.R. 2d 1254 (1956) <i>Gunter v. Lard</i> , 242 La. 943, 140 So. 2d 11 (1962)
Maine	Undecided	Strict enforcement of contract language	<i>Blocker v. Sterling</i> , 251 Md. 55, 246 A. 2d 226 (1968)
Maryland	Valid	Right based on fair contract	<i>Michigan Medical Service, Inc. v. Sharpe</i> , 339 Mich. 574, 64 N.W. 2d 713, A.L.R. 2d 1167 (1954)
Massachusetts	Undecided	Lien theory	<i>National Union Fire Ins. Co. v. Grimes</i> , 153 N.W. 2d 152 (1967)
Michigan	Valid	Assignment of tort action	<i>Travelers Indemnity Co. v. Chumbley</i> , 394 S.W. 2d 418, 19 A.L.R. 3d Forsthaue v. Hardware Dealers Mut. Fire Ins., 416 S.W. 2d 208 (1967)
Minnesota	Undecided	Tort action assignable	<i>Davenport v. State Farm Mut. Auto Ins. Co.</i> , 404 P. 2d 10 (1965)
Mississippi	Invalid	Not disapproved by Legislature nor Insurance Commissioner	<i>Smith v. Motor Club of America Ins. Co.</i> , 54 N.J. Super 37, 148 A. 2d 37 (1959) <i>Aff'd</i> 56 N.J. Super. 203, 152 A. 2d 369 (1959); <i>Certification den.</i> 30 N.J. 563, 154 A. 2d 451 (1959)
Missouri	Invalid	Subrogation different from assignment	<i>Busch v. Home Ins. Co.</i> , 97 N.J. Super. 54, 234 A. 2d 250 (1967)
Montana	Undecided	Strict interpretation of contract language	<i>Morto v. State Farm Mut. Auto Ins. Co.</i> , 462 P. 2d 620 (1969)
Nebraska	Valid	Trust Agreement theory	<i>Miller v. Liberty Mut. Fire Ins. Co.</i> , 264 N.Y.S. 2d 319, (1965) <i>Aff'd</i> 289 N.Y.S. 2d 276 (1968)
Nevada	Valid	Double recovery denied as inequitable	<i>Tart v. Register</i> , 252 N.C. 161, 125 S.E. 2d 754 (1962)
New Hampshire	Valid	Tort action assignable; subrogation not disapproved by Legislature nor Insurance Commissioner	<i>Travelers Ins. Co. v. Lutz</i> , 3 Ohio Misc. 144, 210 N.E. 2d 755 (1964) <i>Travelers Indemnity Co. v. Godfrey</i> , 12 Ohio Misc. 143, 41 Ohio Ops. 2d 166, 230 N.E. 2d 560 (1967)
New Jersey	Valid		
New Mexico	Valid		
New York	Valid		
North Carolina	Valid		
North Dakota	Undecided		
Ohio	Valid		

State	Validity	Theory	Case
Oklahoma	Invalid	Subrogation considered splitting cause of action	<i>Lowden v. Oklahoma Farm Bureau Mut. Ins. Co.</i> , 436 U. 2d 654 (1967)
Oregon	Valid	Double recovery denied as inequitable	<i>Barneier v. Oregon Physicians Service</i> , 144 Ore. 659, 243 P. 2d 1053 (1952); <i>Geertz v. State Farm Fire & Cas. Co.</i> , 451 P. 2d 860 (1968)
Pennsylvania	Valid	Strict construction of contract language	<i>Heis v. Allstate Ins. Co.</i> , 436 P. 2d 550 (1968)
		Double recovery denied as inequitable	<i>Bradford v. American Mut. Liability Ins. Co.</i> , 25 Pa. Super. 8, 245 A. 2d 478 (1968)
		Subrogation different from assignment	<i>Denmery v. National Fire Ins. Co.</i> , 232 A. 2d 21 (1967)
Rhode Island	Valid	By ignoring subrogation	<i>Hospital Service Corp. of R.I. v. Pennsylvania Ins. Co.</i> , 227 A. 2d 105 (1967)
South Carolina	Undecided	acquiesced in splitting of cause of action	*
South Dakota	Undecided	*	*
Tennessee	Valid	Subrogation different from assignment	<i>Tennessee Farmers Mut. Ins. Co. v. Rader</i> , 410 S.W. 2d 171 (1966) <i>Wilson v. Tennessee Farmers Mut. Ins. Co.</i> , 711 S.W. 2d 699 (1967)
Texas	Undecided	*	*
Utah	Valid	Subrogation different from assignment	<i>State Farm Mut. Ins. Co. v. Farmers Ins. Exchange v. Sessions</i> , 450 P. 2d 458 (1968)
Vermont	Undecided	*	*
Virginia	Invalid	Statute	Va. Code Ann. § 38.1 - 38.12 (1968)
Washington	Valid	Double recovery denied as inequitable	<i>Metropolitan Life Ins. Co. v. Ritz</i> , 70 Wash. 2d 317, 422 P. 2d 780 (1967)
W. Virginia	Valid	Not disapproved by Legislature nor Insurance Commissioner	<i>Travelers Indemnity Co. v. Rader</i> , 166 S.E. 2d 157 (1969)
Wisconsin	Valid	Subrogation different from assignment	<i>Associated Hospital Service, Inc. v. Milwaukee Auto Mut. Ins. Co.</i> , 33 Wis. 2d 170, 147 N.W. 2d 225 (1967)
Wyoming	Undecided	*	